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ABSTRACT

A study compared the nurse-patient communication of native and non-native English-speaking nurses. Examination of the literature on nurse-patient relationships and a brief survey of native nurses yielded an instrument for observation of nurses. Ten nurses were observed for 3 hourse each. Transcripts of the observations of the five non-native speakers were examined to extract 46 communicative functions specific to this context. Transcripts of the observations of the five non-native speakers, together with informal interviews with hospital personnel, disclosed the problems that non-native speaking nurses experience in their nurse-patient relationships. The problems fell into six areas: explaining; commenting; expressing intention; direct questioning; eliciting information; and directing or instructing. Two additional areas of concern that emerged were: (1) some nurses' inability to notice patient anxiety or fear and deal with it; and (2) mistaken meaning. To remediate these problems, a course in oral communication skills for non-native nurses was designed. One fully developed unit is presented. Forms and materials used in researcher interactions with the participating hospitals and nurses are also included. (MSE)

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COMMUNICATIVE FUNCTIONS OF THE NURSE-PATIENT RELATIONSHIP: OBSERVATIONS OF NATIVE AND NON-NATIVE NURSES IN UNITED STATES HOSPITALS

A THESIS

Presented to the Faculty of

the Department of TESOL and Applied Linguistics

the School of Intercultural Studies

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts in TESOL

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by

Jo Linda Hadley

August 1991

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To David Owen Hadley
my beloved husband

ABSTRACT

COMMUNICATIVE FUNCTIONS OF THE NURSE-PATIENT RELATIONSHIP:
OBSERVATIONS OF NATIVE AND NON-NATIVE NURSES
IN UNITED STATES HOSPITALS

by

Jo Linda Hadley

In the United States, non-native speaking nurses are common in many hospitals. Coming from a variety of backgrounds, they differ in their ability to communicate in English. Examination of the literature on nurse-patient relationships, and a short survey of native nurses, yielded an observation instrument used to observe ten nurses at local hospitals. Transcripts of observations of the five native speaking nurses were examined to extract forty-six functions of the nurse-patient relationship. The transcripts of the observations of the non-native nurses, together with informal interviews with hospital personnel, disclosed the problems that non-native nurses experienced in their nurse-patient relationships. To remediate these problems a sample course for oral communication skills for non-native nurses was outlined, and one unit has been fully developed.

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INTRODUCTION

> Modern nursing is by no means limited to the giving of expert physical care to the sick, important as this is (Frederich and Notham 1938, 3).

> The art of nursing includes both identification of physiological and psychosocial needs of patients and initiation of a plan to meet those needs with integrated interventions that incorporate the patient's body, mind, autonomy, and wishes (Fenton 1987, 82).

In these definitions of nursing it is clear that nursing consists of more than caring for a sick person's physical needs. The nurse-patient relationship is a dynamic one, requiring that the nurse be highly skilled in interpersonal relationships. Fenton aptly describes nursing as "an empathic and compassionate interpersonal process that supports dependent needs of patients and promotes independence" (Fenton 1987, 82).

Kasch (1986) proffers a theory of nursing based on social interaction focusing on communication. He sees nurses as "communications strategists" who construct specific plans to meet their goals (nursing objectives).

> The metaphor, nurse as communication strategist, provides a framework for identifying nursing objectives functionally related to communication and specific behavioral skills likely to account for effective nursing action (Kasch 1986, 228).

The theories of nursing as a caring, helping, and healing profession are carried out practically by living, breathing beings called nurses. These nurses interact with patients by means of communication, verbal and non-verbal. Text-books for nurses contain sections that pertain

directly to communication (e.g., Lindberg 1983, 3-12; Narrow and Buschle 1987, 124-139; Potter and Perry 1987, 145-160; Wolff, et al. 1983, 17-26). This is obviously an area where nurses need training, expertise, and development. In the theories of nursing proposed by nursing experts as well as in the text-books and articles, language ability is not a factor. However, for non-native speaking nurses, language poses particular problems because of the focus in nursing in America on communication and interaction.

In any nurse-patient relationship, a high degree of ability to communicate orally is mandatory. Routine nursing duties such as assessing or interviewing patients; discussing the patients' condition, needs, or limitations; teaching; or motivating patients, all require sophisticated language competence (Powers and Stansfield 1985).

Two native English speaking nurses who worked in Brazil felt that the language barrier was one of the most difficult areas they faced.

> There is a big difference between being able to read and write in a foreign language and being able to speak it in the actual setting. Many of the expressions, slang terms, and jargon commonly used in the hospital environment are not found in the language texts (Dudas and Dzik 1971, 30).

Culture and language are intertwined and cannot easily be separated. Beliefs, values, and attitudes are all a part of what sets apart one group of people from another. Considerable language ability is required in order to communicate these complicated ideas effectively.

> Therefore, how far an individual really gets 'inside' a second culture is dependent to a great extent on how well he verbalizes and comprehends fairly abstract thoughts. (Rayner and Jones 1972, 140).

All nurses in United States hospitals must be able to speak English. They must have a reading and writing ability that permits them to have a passing score on the NCLEX-RN (the nursing exam that all graduate nurses take in the U.S. to be licensed as registered nurses), they must be able to fill in their own application for employment and they must pass at least one oral interview. However, these requirements do not in any way measure the competence of the prospective nurse in the nurse-patient relationship.

It is essential that non-native speaking nurses be equipped to communicate with patients and that they have specialized instruction that focuses on their particular language needs. In fact, the California State Board of Registered Nursing sent out a publication discussing the nursing shortage. As part of their recommendation that foreign trained nurses be helped to qualify for licensure and perform successfully, they suggest that

> Employers of nurses should implement and evaluate programs designed to increase the communications skills of foreign trained nurses (Board of Registered Nursing 1990, 1)

Not only hospitals, but English language professionals who may be called on to design programs for non-native nurses need to have a better understanding of the scope and

nature of the communication problems faced by non-native nurses and their patients.

In this thesis the communicative functions of the nurse-patient relationship will be identified through observations of native nurses in hospitals in the United States. The communicative problems of the non-native nurse will also be identified through observations and interviews. After isolating the needs of the non-native nurse, specific lessons will be designed to assist non-native nurses in improving their communication skills.

CHAPTER I

NURSE-PATIENT COMMUNICATION: NON-NATIVE NURSES

Anatomy of the Problem

A fifty-one year old man had an acute myocardial infarction (heart attack). After being stabilized and treated at a near-by hospital in a suburb of Los Angeles, he was transferred to a huge metropolitan inner-city hospital. He remained in that hospital for four days and was then discharged home. He returned three weeks later for another seven day stay in the hospital due to recurrent chest pain. Throughout his entire eleven days in the inner-city hospital he did not have even one native speaking nurse who was an employee of the hospital to be his assigned nurse. The one native speaking nurse who gave him direct patient care during the course of his hospitalizations was a registry[1] nurse (personal experience, D. Hadley, April/May 1989). Is this an isolated experience? How does the use of predominantly non-native speaking nurses affect the nurse-patient relationship?

Foreign nurses have been used in America as part of the solution for the nursing shortage for over twenty years. The demand for nurses has not slackened at all. If anything, the requirement for qualified nurses has accelerated (Arbeiter 1988). About 4% of the 1.9 million

nurses (73,423) are foreign nurse graduates "according to government statistics for 1984, the most recent year available" (Arbeiter 1988, 57). All figures for foreign nurse graduates working in this country are estimates, as reliable national statistics do not exist. However, in California the Hospital Council of Southern California was able to estimate that 4,650 foreign nurses were working and had working visas in 1988. "Arthur Sponseller, the Council's vice president of human resources, estimated that about 30,000 of the 200,000 registered nurses in California are foreign educated" (Berkman 1988, 1).

Foreign nurse graduates (FNGs) have been defined as "nurses who have graduated from nursing schools in countries other than the United States" (McCloskey and Aquino 1988, 477). These nurses come from a variety of backgrounds and differ in their ability to communicate in English. Nevertheless, they occupy roles in the hospital that are sensitive, demanding, and critical. These nurses fill the places of native language nurses and are expected to carry out their duties with the identical ability and expertise.

As early as 1971, hospitals were concerned about their FNGs. One study, conducted by Virginia Sweeny (1973) at Montfiore hospital in New York, identified four major conflicts that the hospital had with its foreign nurses: job hopping, educational differences, loneliness, and

language problems. These nurses had studied English in their own countries but found it extremely difficult to understand the rapid speech patterns of Americans (Sweeney 1973).

Barnes (1980) reported that Rayner and Jones (1972) identified three major problems that occurred with exchange nurses. Language was the first problem, followed by the ability to adapt to the exchange nurse role. The third difficulty was other cultural factors not having to do with language. "Rayner sees language facility as the single greatest indicator of ease of adjustment to the country" (Barnes 1980, 21). As far back as 1958, nurses were realizing that knowledge and use of a language were two very different things. Martin and Hunt (writing about the exchange nurse program) stated that there is a big difference between knowing a language and using it daily, "especially in the medical field" (1958, 1667).

There has been very little written about the foreign nurse and the nurse-patient relationship. What has been written indicates that the non-native speaking nurse has real difficulties in this area and would benefit from systematic instruction.

During a summer workshop for foreign nurses designed to help FNGs pass the state board exam, some communication problems of the participants were identified (Allen 1980, 8-12; Barnes 1980, 19-25; Morrison 1980, 12-18). It was

commented that even at that time there was little written on foreign nurses and "even less on the process of communication and the utilization of it by the foreign nurse" (Allen 1980, 8). Although the students had to have "acceptable overall ratings in the areas of written grammar, composition, speech, understanding of the spoken word, and reading comprehension," it was found that the written results did not reflect the actual problems in communication that the students faced during the workshop (Allen 1980, 8).

In describing some of those problems, the difficulty with language became readily apparent. One student answered a mental patient's inquiry as to why she was there by saying, "I am here to explore your mind" (Morrison 1980, 16). Although the student meant that "she was there to allow the patient to talk about whatever was on his mind," this poorly stated comment prevented the nurse from establishing a relationship with the patient (Morrison 1980).

Other students ran into difficulties by establishing relationships that they did not want by poor choice of words. They were also frustrated by their inability to understand what the patients were saying. Barnes (1980) concluded that the problems in speaking English had a negative influence on the nurse-patient relationship.

> It can be assumed that if the nurse has to grope for words, has an accent and has difficulty understanding

> spoken English, forming a therapeutic relationship with patients is more difficult (Barnes 1980, 22).

The communicative problems of Chinese nurses in U.S. hospitals was documented by Sunde (1986). Her work included the results of interviews and questionnaires designed to determine the "communication needs perceived by Chinese nurses themselves and by their American co-workers" (Sunde 1986, xii). The results indicate that the Chinese nurses surveyed felt that "technical exchanges with patients were perceived to be more difficult than more general talk" (Sunde 1986, 54-55). Discussing the patient's condition with the patient, providing discharge instructions, and teaching patients about self-care were found to pose a greater difficulty than answering patient calls, comforting patients, attending to patient care, and making rounds (Sunde 1986).

In the 1970's, there was a great deal of interest in English for Specific Purposes, which included English for medical personnel. A well-known study was done by researchers in England identifying the speech functions of doctors, focusing on the doctor-patient communication in the emergency room (Burton, Candlin, Leather 1976). Another study done in England investigated dentist-patient communication (Coleman and Burton 1985). However, nurse-patient communication studies, if they have been conducted at all, have not been published.

A study of nurse-patient communication will generate valuable information that can guide those in the field of ESL to develop materials and curriculum, and those in the medical field to tackle the job of helping the non-native speaking nurse improve in his/her nurse-patient communication.

Survey of Local Hospitals

Procedure

In order to ascertain if non-native speaking nurses were prevalent in local hospitals and to find out what kind of language instruction is available to them in these hospitals, I conducted a telephone survey. The questionnaire consisted of eight questions (see Appendix A). Thirty hospitals were chosen from the yellow pages of local phone books: the Pasadena, Alhambra, Montebello phone book and the Glendale, Burbank phone book. General medical hospitals were chosen from these names, excluding hospitals dealing only with children, psychiatric care, etc. Eighteen hospitals were contacted, and 14 responded. The initial contact was made with the nurse recruiter or the person in the personnel office responsible for hiring nurses. This person did not always feel competent to answer all the questions, so the answers were sometimes supplied by nursing administrators or nursing educators.

The nurse recruiter was chosen to be surveyed, rather than any other hospital employee, because of his/her involvement in procuring and hiring the prospective nurse. He/she is familiar with the requirements for hiring and the population of nurses in the hospital. I found that the nurse recruiter was overall the best respondent for the questionnaire, depending on the confidence level of the individual. However, some recruiters were hesitant to give out information and referred me to others. Only two nurse recruiters refused to answer the questionnaire.[2]

Twelve of the hospitals had no statistics available as to the number of non-native nurses who work there. Two hospitals stated definitely that they had 30% non-native nurses. Several recruiters were very positive about the percentage of non-native nurses, but some were hesitant; consequently, the percentages of non-native nurses are approximations.

The nurse recruiter or personnel worker responsible for hiring nurses was contacted by telephone and given the following explanation and questionnaire.

The survey and results

I am a Registered Nurse currently working on my M.A. in Teaching English to Speakers of Other Languages (TESOL). I am interested in finding out what difficulties non-native speaking nurses have with the nurse-patient relationship. I want to be able to design lessons that would help them

improve their language ability in order to make their nurse-patient relationship more effective. I would like to have some information about the non-native speaking nurses in your hospital. I am interested in those nurses that speak English as a second language and did their nurses training in another country. Could I ask you a few questions; it will take about 5 minutes of your time?

1. How many beds do you have in your hospital?

This question was asked to establish the size of the hospital. From the fourteen respondents the range was from 150 (two hospitals) to 711 (one hospital). Eight hospitals had more than 300 beds and six had less than 300 beds.

2. How many RN's do you employ at your hospital?

This question was asked in order to get a total number to compute the percentage of nurses that were non-native speakers. The answers varied from 30 (at a 150 bed hospital) to 1,000 at a hospital with 606 beds.

3. How many RNs do you have that are non-native speakers? (Approximately if necessary)

Percentage of non-native nurses to native speaking nurses:

10%	2 hospitals	(606 beds, 1,000 RNs) (711 beds, 750 RNs)
20-25%	3 hospitals	(647 beds, 800 RNs) (351 beds, 400 RNs)(201 beds, 132 RNs)
30%	2 hospitals	(301 beds, 180 RNs) (462 beds, 720 RNs)
40%	1 hospital	(150 beds, 200 RNs)

50%	2 hospitals	(411 beds, 325 RNs) (182 beds, 200 RNs)
75%	1 hospital	(150 beds, 30 RNs)

Two respondents would not give even an approximation, saying the number was unknown. One respondent said she did not want to give an approximation but would say there were "quite a few."

4. What areas or units in the hospital have the highest percentage of non-native speaking nurses?

This question was asked in order to determine if there was a unit or area common to most hospitals where there were mostly non-native speaking nurses. Only these units were selected.

Throughout the hospital	35%	(5 hospitals)
Intensive Care	21%	(3 hospitals)
General Medical/Surgical	14%	(2 hospitals)
Do Not Know	21%	(3 hospitals)

5. What English proficiency is required for nurses to be hired?

6. Are any language tests given by the hospital?

Question five was asked in order to ascertain what English proficiency was required at the time of hiring. In response to sections a-d (see appendix A) none of the hospitals required prior study of English, and in response to question six, none required language tests given by the hospital.[3]

Although none of the hospitals gave English language tests, some indicated that a pharmacology test was given to all applicants, and at times other tests were given in order to work in certain units, e.g., critical care. One hospital required foreign nurses to have passed the Commission on Graduates of Foreign Nursing Schools (CGFNS) exam before employment. The hospitals were unanimous on requiring the ability of applicants to fill out an application and pass at least one oral interview. Nine hospitals indicated that the RNs must pass two oral interviews in order to be employed.

7. Is any English language instruction provided by the hospital?

Thirteen hospitals indicated no instruction was provided. One hospital had a class provided by Mount San Antonio College.

8. Do you think your hospital would be interested in being involved in research in the area of non-native speaking nurses and the nurse-patient relationship?

Out of fourteen hospitals, two were interested in this kind of research. Four were definitely not interested, four were not sure, three chose not to answer the question, and one hospital already had a research facility.

Significance of the findings:

The percentage of non-native speaking nurses to native speaking nurses is significant for my research. First of

all, nine hospitals indicated that the population of non-native speaking nurses was 20-25% or more of the RN population in the hospital. That means that patients will frequently come in contact with non-native speaking nurses.

Secondly, five hospitals (35%) indicated that the non-native speaking nurses were spread evenly throughout the hospital. This has implications in regards to selecting the unit or units for conducting observations of native and non-native speaking nurses. A researcher would be able to go to any unit to observe non-native nurses.

In addition, language requirements are so minimal that they do not begin to address the problem of nurse-patient communication. Thirteen out of fourteen hospitals do not require scores on any tests in order to be employed. One hospital required a passing score on the CGFNS test (Commission on Graduates of Foreign Nursing Schools) before employment. The only measure of oral proficiency was the required interview.

It was important to all the hospitals that the nurses be able to communicate with the patients, and one hospital indicated it was also very important that nurses be able to communicate with the doctors. One recruiter detailed the interview process by remarking that if he had to rephrase a question "two or three times" that nurse would be told that he/she would probably find the experience of working at that hospital too frustrating.

Only one of the hospitals provided a class for nurses specifically for English in the hospital setting. This class was produced and conducted by Mount San Antonio Community College. According to the nurse educator, this class included "hospital slang, situational topics, and American culture." It was open to all nurses no matter how long they had been employed at the hospital. It consisted of six two and one-half hour lessons. Two hospitals indicated they currently had classes in Spanish for medical personnel, but they did not have English classes.

Several large hospitals with their own research staff indicated they were interested in this subject for their own research and development. Although the number of hospitals interested in this kind of research is not large, nevertheless, this is an important area to investigate.

Some hospitals indicated they could not be interested in researching this area because they desperately needed nurses. Anything that might prevent a nurse from being hired could be interpreted as threatening. Some hospitals appeared reluctant to acknowledge that their non-native speaking nurses might have a problem with English. Stricter requirements for language ability would make the difficult job of finding qualified nurses even harder.

This survey was enlightening and helpful for my research purposes, but it is unlikely that generalizations can be drawn from so small a sample.

The Research Questions

1. What are the communicative functions of the nurse-patient relationship?

2. Do non-native speaking nurses in American hospitals have problems with the communicative functions of the nurse-patient relationship?

3. If so, what are the problems as observed by a researcher in the hospital setting?

4. In what way can the unique problems that the non-native speaking nurse has with the nurse-patient relationship be addressed for the combined benefit of non-native speaking nurses, patients, and hospitals?

Significance for TESOL

Because there is very little published material about professional nurses and their communication problems and no known material specifically on nurse-patient communication, this study can provide needed information and practical helps where very little exists. At a time when the nursing shortage grows more critical, and the recruitment of foreign nurses is increasing, the problem of non-native speaking nurses and their ability to handle the communicative responsibilities of the nurse-patient relationship needs to be assessed.

There may be a reluctance on the part of medical personnel to delve into this problem. Exposing the problem

without offering any solutions would be useless and even dangerous to the public image of hospitals. This study could offer hospitals practical solutions by identifying the functions the non-native speaking nurses need to know in order to communicate with their patients. Communicative lessons could then be developed to use in the orientation of new nurses to the hospital.

In addition to the service rendered to hospitals this study has much to offer the field of TESOL. Currently, there is great interest in Vocational English as a Second Language (VESL), and this study could add to the present body of knowledge in that area. Although VESL programs are being designed primarily for recent immigrants entering the work force, more needs to be done for those individuals already in the professions.

Finally, researchers in English for Specific Purposes (ESP) along with material and curriculum developers will find the information valuable for a model for other courses for health-care professionals.

Developing the Solution

Identifying Nurse-Patient Communicative Functions

Needs analysis

It used to be that students of foreign languages would go into a classroom and expect to be taught how to speak, read, and write in that language. It was generally accepted that there was a generic language program (one size fits all) that would meet every need. Recently, through research and study, specialists have realized that some people have unique language needs that require specific methods and techniques to facilitate optimum learning.

It has been determined that language learning problems have less to do with linguistic difficulties than previously thought. Many of the problems of language learners are directly due to the difficulties inherent in social and circumstantial situations. "A detailed analysis of the situations of language use is a prerequisite even to the selection of the particular linguistic forms or structures that ought to be taught" (Schutz and Derwing 1981, 31).

Instead of one program for every conceivable student, the learners' needs are given consideration before the program is developed. Knowing what to teach requires understanding what the learners want to do with the language, as well as what their actual communication needs

entail (Widdowson 1978). This kind of learner-centered method for determining a language program is termed "needs analysis."

There are two principal ways of conducting a needs analysis:

a. The use of questionnaires or surveys and/or interviews or checklists.

b. The accumulation of data about use of the language by native speakers in the situation in which the language learner will be expected to communicate (Mackay and Bosquet 1978).

One of the difficulties with the first way (questionnaire, etc.) is that learners often do not have a realistic picture of their own language difficulties. A questionnaire was administered to both Chinese nurses and American nurses working in U.S. hospitals. The Chinese nurses filled out self ratings in the areas of pronunciation, talking on the telephone, talking in person, etc. The American nurses used the questionnaire to rate the Chinese nurses they worked with in the same areas. The study found that there were large variations in the problem areas the Chinese nurses selected versus the problem areas that the American nurses selected (Sunde 1986).

Additionally, it was discovered that the American nurses selected skill areas as being a problem more often than Chinese nurses did (Sunde 1986). This appeared to

represent the inability of many Chinese nurses to recognize their own communication problems in English.

The second way to conduct a needs analysis does not rely on the learners' awareness of his own language problems. It is called a target situation analysis (TSA). It is accomplished by the researcher going into a real-life situation and finding and organizing the data. The objective is to identify the communication that actually occurs, including not only the grammatical forms but also the language functions. The items identified form the base for formulating the goals and objectives of the language course (Chambers 1980).

According to Mackay (1978), teachers and planners need to look into the communicative uses of the language for themselves. He felt that non-linguistically trained people did not have the expertise to distinguish skills. They lack the ability to judge the degree of English proficiency needed in order to accomplish specific language functions. They do not realize exactly how much time and energy is required in order to be able to have a basic ability in the English language. It therefore becomes essential for teachers and planners to investigate the actual situation in which the language will be used in order to prepare effective language lessons.

In this thesis I will be using a target situation analysis (observation) for the purpose of determining just

what nurses do (communicatively) in the nurse-patient relationship. I will also be using a review of the literature, textbooks, and M.A. theses on the nurse-patient relationship, in order to help identify the functions.

Preparing Materials

The functional/notional approach

The functional/notional approach is basically an emphasis on the use of the language rather than on its grammatical forms.

> Any act of speech is functionally organized (that is, it is an attempt to do something) for a particular situation in relation to a particular topic. The language that we actually produce changes when these elements change, because we have learned to adjust our language use to be appropriate for the conditions in which we use it (Finnochiario and Brumfit 1983, 13).

Communication occurs in many different kinds of social interactions, each with many different factors that influence the speech act. Greeting a friend; asking directions to the post office; and discussing a painting, a sculpture, or a beautiful landscape are all language functions. Inviting someone to dinner, telling someone to do something or not to do something, and giving advice are more examples of functions.

> . . . the social roles and the psychological attitudes of the participants toward each other in a conversation
> . . . the place and time of the communication act, and the activity or topic being discussed will determine to a large extent the form, tone, and appropriateness of any oral or written message (Finnochiario and Brumfit 1983, 22).

In 1975, the Council of Europe developed a list of functions (see Appendix B) that they considered necessary for a person to have reached a threshold level of a foreign language. Being at the threshold level indicates that the individual has reached a general language ability. This means that learners will be able to carry out the activities of daily living even in those areas in which they have not had instruction (Van Ek and Alexander 1975).

These functions are basic ones found in the languages spoken by members of the council of Europe. It is not a complete list because it is impossible to form one, but it is intended to be basic. Other functions would be included at a higher proficiency level (Van Ek and Alexander 1975).

For these reasons, this list was chosen over other lists for use as a starting place in determining the functions of nurse-patient communication. In the next chapter I will detail how the research was developed from the list.

Course models for health professionals

Having a communication course for professional nurses requires a specialized curriculum. Other health profession courses can give valuable assistance in designing oral communication classes for nurses. A course for non-native pharmacy students used a combination of content-area ESL and ESP in order to improve the communicative ability of non-native pharmacy students. This course utilized

teaching on principles of communication as well as focusing on the functions that the pharmacists would use daily on the job (Graham and Beardsley 1986).

Using communication information from the field of communication theory as the basis for a course could provide the professional input and updating of skills very necessary for nurses. It also allows for applying specific techniques of English teaching in order to improve communicative language ability.

The sheer magnitude of materials, papers, and journal articles about the communication needs of foreign medical graduates and foreign medical students demands that they be mentioned as well (Maher 1986; van Naerssen 1979; van Naerssen 1980; Tyacke 1976). Many general principles of communicating in the health professions can be transferred from one course to another. Courses developed for pharmacists or doctors cannot be used in substitution for courses designed for nurses because nurses' individual needs are too unique.

A program design model presented by Mary J. Schleppegrell at TESOL '90 provided a step by step approach to course design, which was supplemental to Mackay and Bosquet's (1978) work on program design. Current courses for health personnel such as the program developed by the Jewish services in Chicago (Kessler and Mrowicki n.d.) and Mount San Antonio College in San Dimas, California (Karet

and Bader, n.d.) were very general, attempting to be suitable for many different health professions, but they were also helpful.

The components of this specific course will consist of content on communication principles (from nursing textbooks and journals) and practice based on the functions identified from the observations.

In the next chapter the actual process of identifying the functions of the nurse-patient relationship will be detailed.

CHAPTER II

IDENTIFYING COMMUNICATIVE FUNCTIONS FOR NURSE-PATIENT COMMUNICATION

Functions Selected Through a Survey

Development of the Survey Instrument

A simple survey (see Appendix C) was given to six native speaking RNs in order to see if my intuitions about what functions nurses used in the nurse-patient relationship were correct. I gave them a copy of the functions identified by Van Ek (1975) (see appendix B) and asked them to indicate which ones best described what they did or said in contacts with patients. I wanted to extract from a general list some specific items that would pertain particularly to nurses.

The surveys were passed out to RNs, and five of those were returned completed. One survey was only half completed and was not used in the tally. Three of the RNs are currently working with patients, one of the respondents is home on maternity leave, and one RN (with thirteen years experience) is currently a student in another field.

Survey Results

The functions in category A (see Table 1) were determined by all five nurses to be used in every patient contact (see the heading EVERY TIME). Category B

includes the functions that were used the majority of the time. This was indicated by four nurses agreeing that they used the functions either all the time or some of the time. For example, if two nurses indicated that they used the function 3.8 (inquiring about satisfaction or dissatisfaction) all of the time, and two nurses indicated they used it some of the time, that function would be included under category B. For the purposes of prioritizing, these functions are grouped under the heading MOST OF THE TIME.

Included in category C were the functions that three or more nurses agreed they used only in some of their contacts, never indicating they were used all of the time. (see the heading SOME OF THE TIME). All other functions were eliminated. The functions chosen by the nurses from the list are presented in order of priority. The original numberings were taken from Van Ek (1975).

Table 1

Functions Chosen From Nurses Survey

Category A:
EVERY TIME
1.4 asking
6.1 to greet people
6.2 meeting people
5.1 suggesting a course of action (including the speaker)

Category B:
MOST OF THE TIME
3.8 inquiring about satisfaction or dissatisfaction
2.8 stating whether one remembers or has forgotten something or someone
2.11 inquiring whether something is considered possible or impossible

Table 1 (cont).

2.13 inquiring about capability or incapability
2.17 inquiring how certain/uncertain others are of something
2.18 expressing others are/are not obliged to do something
3.11 inquiring about fear or worry
3.13 inquiring about preference
3.14 expressing gratitude
4.1 apologizing
4.5 inquiring about approval or disapproval
5.3 inviting others to do something
2.22 giving and seeking permission to do something
3.3 inquiring about pleasure, displeasure,likes, dislikes
3.5 expressing hope
3.19 inquiring about want, desire
1.1 identifying
1.2 reporting (including describing and narrating)
2.7 offering to do something
2.9 inquiring whether someone remembers or has forgotten something or someone.
5.2 requesting others to do something
5.5 warning others to take care of or refrain from doing something
5.6 instructing or directing others to do something
6.3 introducing people and being introduced
6.4 taking leave
1.3 correcting
2.2 inquiring about agreement or disagreement
3.15 expressing sympathy
4.6 expressing appreciation
3.16 expressing intention
3.17 inquiring about intention
4.2 granting forgiveness
5.4 advising others to do something

Category C:
SOME OF THE TIME
2.6 inquiring whether offer or invitation is accepted or declined
2.10 expressing whether something is considered possible or impossible
2.12 expressing capability or incapability
2.14 expressing whether something is considered a logical conclusion (deduction).
2.15 expressing how certain/uncertain one is of something
3.18 expressing want, desire
2.23 inquiring whether others have permission to do something
2.24 stating that permission is withheld.
3.12 expressing preference
2.1 expressing agreement and disagreement

Table 1 (cont).

4.3 expressing approval

Functions Eliminated
4.8 expressing indifference
6.6 proposing a toast
4.7 expressing regret
6.5 attracting attention
3.6 expressing dissatisfaction
3.9 expressing disappointment
6.7 beginning a meal
2.3 denying something
2.4 accepting an offer or invitation
2.5 declining an offer or invitation
3.2 expressing displeasure, dislike
3.4 expressing surprise
3.10 expressing fear or worry
4.4 expressing disapproval

Interpretation of the Survey

Four items were chosen by all five respondents as functions that were used in every contact with patients. These functions were: greeting people (6.1), meeting people (6.2), suggesting a course of action (including the speaker) (5.1), and asking (1.4).

Being able to properly greet and meet people is given top priority by these respondents as well as being able to suggest a course of action. Many nurses use the pronouns "we" or "us" when suggesting a course of action even though that practice is not recommended by nurse educators. It can sometimes lead to difficulties, as when a young nurse suggested to an elderly gentleman that is was "time we got into bed" and he kindly suggested that she go first!

"Asking" may be a category under which all the "inquiring" items would neatly fit. The fact that fourteen of them started with the word "inquiring" seems significant. Twelve of the items were in either category A or B (the two highest priorities) and two of them were chosen for category C. None of the items on the original Van Ek list beginning with the word "inquiring" was eliminated. This underscores the importance of non-native speaking nurses being able to inquire appropriately.

In contrast, twenty-two of the items on the Van Ek list began with the word "expressing." Out of these items, thirteen were either chosen by the respondents for category A or assigned to category B, three were chosen for category C, and seven were eliminated.

Having the ability to be expressive in some ways and not in others appears to be important. All five nurses agreed they hardly ever expressed indifference in their patient contacts, and four out of five agreed that they hardly ever expressed regret, dissatisfaction, or disappointment. What functions to avoid may be as important to stress to non-native speaking nurses as the functions to add.

The sample is too small to lead to any generalizations. No examples were provided, so each respondent had to give her own interpretation to the meaning of each function, and some wordings may have been confusing or

obscure. There should have been an extra category between "every contact with patients" and "some contacts with patients". Some of the functions fell in between these two groupings causing it to be difficult to choose either one or the other. This probably made prioritizing more difficult.

The purpose of the survey was accomplished by identifying some of the functions particular to the nurse-patient relationship. This small survey also was helpful in discovering where to start in the building of an observation instrument.

Functions Selected Through The Literature

Nurse-Patient Relationship Defined In Nursing Literature

It is essential that the nurse-patient relationship be defined precisely in order to understand the unique nature of the nurses' communicative needs. This relationship is a dynamic one with considerably more depth than a casual interaction. It is sometimes referred to as the helping relationship or facilitative (therapeutic) communication (Sundberg 1989; Potter and Perry 1987; Taylor, Lillis, and LeMone 1989; Narrow and Buschle 1987).

This relationship is based on basic communication theory and involves the use of communicative techniques (or language functions). There are basically two kinds of

nursing functions, expressive (supportive) or task-oriented (instrumental, technical). Whereas the task-oriented functions are necessary for promoting full recovery when a person has a physiological response to illness, the expressive functions help the ill person deal with psychosocial demands (Fenton 1987).

> Interventions are intended to help the patient feel cared for, secure, hopeful, confident, comprehending and knowledgeable and to minimize the patient's fear, anxiety, confusion, loneliness, and isolation (Fenton 1987, 82).

Due to the nurse-patient relationship being communication based, it requires a high degree of competence in English to be able to operate in it effectively. This is a high, "ideal" standard that both native and non-native nurses would be judged on. If non-native speaking nurses do not live up to the expected standard, it could be due to cultural differences, lack of training in their home countries, lack of English ability, and/or the personality of the individual. Although it may not be possible to determine the exact cause, it can be assumed that English classes concentrating on the nurse-patient relationship would give needed assistance to the non-native speaking nurse.

Functions Selected

Since it has been shown that the nurse-patient relationship is dynamic and communicative, it follows that

it could be described in terms of language functions. The functions in Table 2 were chosen from eight sources, (Brown 1986; Di Salvo and Backus 1981; Lindberg, 1983; Taylor, Lillis, and LeMone 1989; Narrow and Buschle 1987; Sundberg 1989; Wolf 1986; Wolff, et al. 1983). These are descriptive terms for objective communicative functions. Functions that were subjective or unclear were not chosen. The functions in Table 2 were categorized into three groups: non-verbal, inquiring or questioning, and expressing.

Table 2

Functions Chosen from Literature

NON-VERBAL:
Attentive listening
Touch
Silence
Gestures

INQUIRING OR QUESTIONING:
Direct (obtains specific information)
Open-ended questions
Reflecting (reflective question/comment)
Clarifying
Summarizing (restating-paraphrasing)
Validating question
Sequencing question (places events in chronological order)
Closed question (extracts the exact response being sought)
Soliciting feedback

EXPRESSING:
Reassurance
Comfort
Giving feedback
Motivation
Advice
Picking up and responding to cues
Describing behaviors (avoiding labels)
Acceptance and understanding

Functions Identified Through Target Situation Analysis

Methods and Procedures

The best way to determine which of the identified functions non-native nurses might have difficulty with is through the use of observation. The behavioral sciences have extensively used this technique. Observation requires a designated person to attend to the behavior of a particular person or group. This observation is done in the natural surroundings for a limited amount of time (Henerson, Lyons-Morris, and Fitz-Gibbon 1978).

For the purposes of recording both the presence of certain functions and the number of times they occurred, a modified checklist was developed. In the preliminary instrument all the functions identified were listed, and a code was given to each function. This enabled the observer to mark down the functions that would be used in the order they occurred. The results of the checklists could show not only a tally of the number of times a function was used during the observation period but the pattern of use of the functions (Burton, Candlin, and Leather 1976).

The preliminary instrument was piloted on a video distributed by the American Journal of Nursing, "Your participation in Recovery From Surgery." This provided for practice and memorization of the code numbers before observations of nurses began. Also functions could be

eliminated or prioritized according to their frequency on the video.

The piloting of the checklist on the video did not yield the desired results. It showed that translating the words of the nurse into functions simultaneously was impractical. Therefore, in the hospital observations, the nurses' interactions with their patients were noted fully, then the functions were identified as soon after the observation as possible. After some experience with the observations, the identified functions could be noted in code form immediately. A transcript was made of each observation, and after the functions were identified a tally was taken which yielded the number of times each nurse used each identified function.

Goals of the Observation

The observations were done, not only to find out some interesting and useful information, but specifically to help in the design of relevant materials for classes for non-native speaking nurses. With that in mind the goals of the observations were:

1. To distinguish the communicative functions used by native speaking nurses.
2. To identify the functions used most frequently.
3. To distinguish a pattern or order in the use of the functions.

4. To identify differences between the functions native speakers use and those that non-native speakers use or omit.

The observation instrument was formulated within the framework of these goals.

Development of the Instrument

I first organized the identified functions under the headings used in a functional course (Hendrickson 1986) in order to develop categories for the functions of the nurse patient relationship (see Table 3). An additional category was added to accommodate the non-verbal functions identified. The categories and preliminary list of identified functions are listed under Table 4.

Table 3

Categories of Identified Functions

Socializing (S)
Maintaining Closer Relationships (MCR)
Influencing Peoples Actions (IPA)
Making judgments (MJ)
Inquiring (I)
Non-Verbal (NV)

Table 4

Preliminary list of Identified Functions

Socializing:

6.1 greeting people
6.2 meeting people
5.3 inviting others to do something
6.3 introducing people and people are being introduced
6.4 taking leave

Maintaining Closer Relationships:

3.8 inquiring about satisfaction or dissatisfaction
2.8 stating whether one remembers or has forgotten something or someone
3.14 expressing gratitude
4.1 apologizing
4.5 inquiring about approval or disapproval
3.3 inquiring about pleasure, displeasure, likes, and dislikes
3.5 expressing hope
2.7 offering to do something
3.15 expressing sympathy
4.6 expressing appreciation
4.2 granting forgiveness
3.18 expressing want, desire
3.12 expressing preference
2.1 expressing agreement and disagreement
4.3 expressing approval
4.4 expressing disapproval
picking up and responding to cues
describing behaviors (avoiding labels)
expressing acceptance and understanding
expressing reassurance
expressing comfort
expressing feedback

Influencing Peoples Actions:

5.1 suggesting a course of action (including the speaker)
2.18 expressing one is/is not obliged to do something
2.22 giving and seeking permission to do something
5.2 requesting others to do something
5.5 warning others to take care of or refrain from doing something
5.6 instructing or directing others to do something
1.3 correcting
3.16 expressing intention
5.4 advising others to do something

Table 4 (cont.)

2.20 expressing others are/are not obliged to do something
2.24 stating that permission is withheld.
motivating
1.2 reporting (including describing and narrating)

Making Judgments:

2.10 expressing whether something is considered possible or impossible
2.12 expressing capability or incapability.
2.14 expressing whether something is considered a logical conclusion (deduction)
2.15 expressing how certain/uncertain one is of something

Inquiring:

1.4 asking
2.11 inquiring whether something is considered possible or impossible
2.13 inquiring about capability or incapability
3.11 inquiring about fear or worry
3.13 inquiring about preference
3.19 inquiring about want, desire
1.1 identifying
2.9 inquiring whether someone remembers or has forgotten
2.2 inquiring about agreement or disagreement
3.17 inquiring about intention
2.6 inquiring whether offer or invitation is accepted or declined
2.23 inquiring whether others have permission to do something

direct questioning (obtains specific information)
open ended-questions
reflecting
clarifying
summarizing (restating-paraphrasing)
validating
sequencing (places events in chronological order

Non-Verbal:

Touch
Silence
Gestures
Attentive listening

Subjects Selected

During the hospital survey two hospitals expressed interest in being a research site for this study. They will be referred to as hospital A and hospital B. Hospital A offered two locations for the observations. These two locations were the surgical units (including orthopedics) and the medical units. I sent a proposal and an informed consent form to the nurse recruiter who routed it to the nurse educator. This proposal outlined my specifications.

I asked to observe 10 different nurses at hospital A as my plan was to observe five non-native (foreign trained) nurses and five native nurses. Although I originally would have liked to observe non-native speaking nurses who were working in the hospital as their first job in the U.S, and had been at the hospital for less than a year, this did not turn out to be practical. I had assumed that new employees would have more difficulty with the nurse-patient relationship than long term employees. However, I was willing to work with the hospital on researching the problems of their non-native speaking nurses who have been in the U.S. for longer periods or worked in other locations. This would give the picture of language problems of long term non-native speaking RNs.

The nurse managers were asked to select native speaking nurses that were considered by patients or staff to have exceptionally good nurse-patient communication skills

(by recommendation of a supervisor, patient letters, or praise received, etc.). They were to be nurses who trained totally in the United States and spoke English as their first language.

I met with the unit manager of the surgical floor which had 140 employees, and she gave me the names of six nurses. I was given a list of the names and phone numbers in order to contact the nurses to solicit their participation. The unit manager put a proposal (appendix D) and an informed consent form (appendix E) where the selected nurses get all their memos and other information from their unit manager.

The unit manager gave me a work schedule for the nurses so I was able to arrange the observations according to their schedules.

The unit manager of the medical unit was not able to meet with me. However, she selected two participants who agreed to be a part of the study.

All observations were done on the day shift to provide continuity of situations observed. All the participants were asked to fill out an information sheet (Appendix F and G); there were separate sheets for native speakers and non-native speakers. They each signed an informed consent form before the observations began. I observed nurses on the diabetic unit, the oncology/pulmonary unit, the general medical unit, and the general surgery unit.

In hospital B, my initial contact was with the nurse recruiter. She took my proposal to the Nursing Administration, and after receiving permission I was referred to the nurse educator. She contacted head nurses and collaborated with them on the selection of the nurses for observation. She personally contacted each nurse who was selected and obtained his/her permission. She scheduled all the observations after learning what days I would be available. On the first day of observations at this hospital she escorted me to the floor and introduced me to the head nurse and the nurse I would be observing.

At this hospital eight nurses were observed, seven NNS nurses and one NS nurse. I observed five nurses on the day shift and two nurses on the evening shift. I went to three different areas: medical/oncology unit, surgical/orthopedic unit, and the direct observation unit (where patients have recently been in the intensive care and require close monitoring).

I observed a total of 16 nurses (all female) obtaining the transcripts of five NS nurses and five NNS nurses who qualified for my criteria. The transcripts of six NNS nurses were eliminated: one NNS nurse was only observed for 1 1/2 hours, and three NNS nurses had done all or part of their training in the United States or Canada, and two other NNS nurses had been observed on the p.m. (3-11 or evening) shift.

As the principal researcher I spent three hours with each nurse, following her and noting down her interactions with patients. Although I originally wanted to note non-verbal as well as verbal interactions, this did not prove to be practical. Non-verbal interactions were usually noted when they were prolonged (attentive listening) or very noticeable.

I was discouraged strongly by the unit manager at hospital A and the nurse educator at hospital B from using a tape recorder. In order to tape record interactions between patients and nurses, any patients involved would have to have signed an informed consent form. This would have been very time consuming as well as awkward. As useful as a tape recording would have been, I chose instead to take copious notes and to transcribe them as soon after the observation as possible. I felt that trying to obtain consents for participation from both the patients and the nurse would cause the interactions to be strained and less than spontaneous.

After the functions were preliminarily identified and the sights and subjects selected, the process of observing the nurses in the hospital setting occurred. The process of collecting the data, analyzing the data, and determining the significance of the data will be detailed in the next chapter.

CHAPTER III

COLLECTION, AND SIGNIFICANCE OF THE DATA

Collection of the Data

Utilizing the preliminary list of identified functions, the transcripts of the native-speakers were examined and a list of 57 functions identified. Those functions were scrutinized closely to see if any of them could be combined. After this procedure a final list of 43 functions was finalized, then the non-native speakers' transcripts were examined. During the examination of the non-native speakers' transcripts three additional functions were noted. This process produced a final list of 46 functions with examples (see Table 5).

Table 5

Identified Functions From Observations

1. Introducing
   - A. My name is Francis
   - B. This is Mr. T
2. Confirming/Restating
   - A. patient (Pt)-Can I have a pain shot?
     Nurse-You need a pain shot
   - B. How long have you been here?
     Pt-since Monday
     Nurse-You've been here a week
3. Direct Questioning
   - A. How do you say your last name?
   - B. Are you having pain?
4. Commenting/Stating/Observing
   - A. Just hit and miss
   - B. You've got tough skin
   - C. You've still got your bottles (IV's)

Table 5 (cont.)

D. You've been on a low sodium diet
E. Thirsty, huh
F. You didn't swallow that
G. Your hand appears to be swollen

5. Expressing Intention
   A. Going to be a stick
   B. Let me lift you up a little bit
   C. We'll do something about it
   D. Let me take your vital signs first, then I'll get you up to the bathroom
   E. We're going to wash your back
   F. I'll ask the Doctor
6. Touching
   A. Touched the Pt on the arm in greeting
7. Transitional
   A. There you go
   B. Ok
8. Leave Taking/Intention To Return
   A. I'll be back in a little bit
   B. I'll be right back
   C. Take good care
9. Acknowledging/Conversation Ease
   A. Pt-your going to check on my shot?
   B. Yeah
   C. ok
   D. uh huh
   E. hmmmm
10. Greeting/Getting Attention
   A. Hello
   B. Good morning
   C. Mrs. _____?
11. Inquiring About Patient's Condition
   A. How are you feeling?
   B. How are you this morning?
   C. Are you feeling strong enough to walk that far?
   D. Are you comfortable?
12. Socializing/Talk
   A. Almost breakfast time
   B. Have a good day
   C. Is that your neighbor?
   D. She's your granddaughter?
   E. Where do you work?
13. Explaining
   A. Because the secretary called me and said they're not going to do you til 2:30.
   B. So I can give you your medicine
   C. Possibly there's some bleeding going on
   D. We're still checking the availability
   E. Just checking to see if everything's Ok

Table 5 (cont.)

14. Directing/Instructing
    A. Get up in the bed
    B. Sit up a little further
    C. Swallow your medication
    D. You've got to take this pill
15. Informing
    A. I'll be your nurse for today
    B. It will be in your IV
    C. After breakfast you can't eat
    D. So after breakfast, nothing
    E. You're also supposed to have a bone marrow
16. Suggesting/Advising
    A. Let's just do it in your arm
    B. Let's get your breakfast in and you can lie down
    C. How about eggs?
17. Eliciting Information
    A. What happened?
    B. Tell me where it hurts on your back.
    C Does it bother you at all, the IV's?
    D. Tell me, do you have a pain anywhere?
    E. Any other questions?
18. Expressing Need To Wait
    A. Just a minute
    B. Hang on a minute
    C. Just a second
19. Verifying
    A. And you feel like your back is hurt
    B. Pt-Why two?
       Twice a day you mean?
    C. Dr. G____ said one week, right?
20. Reassuring
    A. Its OK
    B. I know
    C. That's OK
    D. OK, honey
    E. I'll take care of it
21. Inquiring About Agreement/Disagreement
    A. OK?
    B. Well at least your among friends
22. Approving
    A. OK
    B. Good
    C. That's good
    D. That's right
    E. That's better
23. Apologizing
    A. I'm so sorry

Table 5 (cont.)

24. Inquiring About Satisfaction/Dissatisfaction
    A. OK?
    B. Is that better?
    C. Alright?
    D. How's that, good?
25. Inquiring About Want/Desire
    A. Feel like going home?
    B. Ready to go out to the bathroom yet?
    C. Want some cream?
    D. Want some sugar?
    E. We can just do it from the bed if you want
    F. Do you want to wash. . . or do you want me to?
26. Expressing Want/Desire
    A. I don't want you getting out of bed by yourself anymore
    B. I want you to give me a call
    C. I want to check your IV
27. Giving Opinion
    A. I think you probably wrenched your shoulder
28. Expressing Agreement
    A. OK
    B. Pt-They [the nurses] don't get a chance to relax
       Nurse-No, we certainly can't relax on this job
    C. Right
29. Comforting/Encouraging
    A. You'll feel a lot better
    B. You're a good assistant
30. Inquiring About Capability/Incapability
    A. No, Can't do it?
    B. Can you sit up for me just a minute so I can listen to your lungs?
    C. Can you get your hands up here...?
    D. Can you bring the mucous up?
    E. Can you hold onto that?
31. Clarifying
    A. Two of the vasotech tablets?
    B. Is that what your saying?
32. Offering Something/To Do Something
    A. Some more coffee?
    B. Any questions? I'll be glad to answer them
    C. How about some orange juice
    D. Shall I get you one?
33. Rhetorical Questioning
    A. What have we got here?
34. Expressing Possibility
    A. He'll be in and look at your BP [Blood Pressure]
    B. Maybe he'll adjust your medication
35. Expressing Acceptance And Understanding
    A. I know how that is...
    B. I know

Table 5 (cont.)

36. Granting Permission
    A. Go ahead
    B. Ok, go ahead
    C. OK we can go ahead now
37. Expressing Doubt/Uncertainty
    A. I don't know the doctor hasn't written orders today
    B. Pt-Do you have the result?
       Nurse-Don't know, takes 2 1/2 hours
    C. No, I don't think I did
    D. I don't know when he'll be here
38. Expressing Gratitude/Politeness
    A. Thank you
    B. Excuse me
    C. Please
39. Attentive Listening
40. Expressing ApprovalDisapproval
    A. No, no, no [Pt spits out pills]
    B. I'm going to call the doctor on you and tell him you're not taking your pill
41. Eye Contact
42. Expressing Disagreement
    A. Oh no
43. Stating Permission Is Withheld
    A. No you can't have any you have a tube in your nose
44. Asking Permission
    A. Can I put this in the closet here?
    B. May I change your dressing while you're standing up?
45. Being Understood
    A. Nurse-Did you get sick last time? [Pt doesn't understand]
       Nurse-Did you get sick? [Pt doesn't understand]
       Nurse-Did you throw up?
       Pt-once
    B. Nurse-I'll put this plastic bag so you can put your tissues
       Pt-What?
       Nurse-Your tissues
       Pt-What?
       Nurse-Your kleenex
46. Understanding Patients
    A. Nurse-They burned what?
       Nurse-What burns?
       Nurse-What did you say, I didn't get it?
    B. What?
    C. Nurse-Are you done?
       Pt-I've done the best I can do.
       Nurse-What?
       Pt-I've done the best I can do
       Nurse-Is it finished? Is it all done?

My observations of the native nurses included a total of 89 interactions, an interaction consisting of a conversation of any length between the nurse being observed and a patient. During these interactions 47 functions were identified. The six most frequent were: expressing intention (192 times), comment/ statement/observation (162 times), inform (153 times), direct question (139 times), transitional (116 times) (see Table 6).

Table 6

Six Most Frequent Functions: Native Nurses

1. Expressing Intention (192 times)
2. Commenting Stating/Observing (162 times)
3. Informing (153 times)
4. Direct Questioning (146 times)
5. Directing/Instructing (139 times)
6. Transitional (116 times)

My observation of the non-native nurses included a total of 111 interactions. The twenty-two additional interactions may have been by chance, or it may mean that the non-native nurses are with the patients more often. There was some variation on which functions the non-native nurses used more frequently (see Table 7).

Table 7

Six Most Frequent Functions: Non-native Nurses

1. Commenting (150 times)
2. Direct Questioning (110 times)
3. Informing (108 times)
4. Socializing/Talking (100 times)
5. Explaining (90 times)
6. Directing/Instructing (75 times)

This sample is so small and there are so many variables that conclusions cannot be drawn statistically. The greatest benefit of these observations was in identifying the nurse-patient communication functions and through personal observation of the nurses determining which functions were the most problematic.

Problem Areas Identified

Besides identifying common nurse-patient communicative functions, my research also looked for specific communication problems that non-native nurses had. Transcripts were examined for instances of communication breakdown (see Table 8).

During the observations it became apparent that the communication difficulties were mispronunciations or tangled syntax. Beyond that, these nurses had difficulties with inadvertently causing miscommunications, and more

importantly, had problems picking up on what their patients really meant by what they were saying.

Table 8

Examples of Communication Problems: Non-native nurses

1. Explaining

A. I have to shave it because the tape. When we tear it off we won't tear your hair. Some one they don't know why, they don't like it we shave their hair, it's their attractive.

B. They draw you blood for that thing, draw to see, to check if the amount we give you is correct a little bit increase or decrease.

C. Yesterday I put this one here and I have to take off.

D. The most important is to regulate. Sometimes the medicine do that.

2. Commenting

A. You give it back to me. (commenting on a patient who vomited)

B. You don't have no salt.

C. This is big trouble, nobody give the tray.

D. Maybe we let respirator do treatment on you.

3. Expressing Intention

A. All right, I will give you. I will give insulin then after breakfast the pain pill.

B. Let me slow this down. (Turning the T.V. down).

C. I have to let you turn to the other side.

4. Direct Questioning

A. They didn't never start it anymore?

B. You want take a pain pill now?

C. Did respirator come do treatment on you?

D. Did they do this in the morning? Did nobody do this?

Table 8 (cont.)

5. Eliciting Information

A. Sensation, do you have problem when I touch you, you can feel it all over your body?

B. Do you worry about something?
Something in your mind?
Then why you look unhappy today?

C. So you have pain on your arms?

6. Directing/ Instructing

A. Next time when you get up, don't get up right away. (Pt had fainted)

B. (Conducting a neurological exam)
Try to squeeze me, as heavy as you can.

C. Move your leg over, otherwise you will get break from the side rail.

One nurse, intent on getting a surgical consent signed, never picked up on the fact that the patient was worried and concerned about the procedure. In fact, it was difficult to ascertain how much the patient actually understood from the comments the patient made.

> Mrs. Smith: What is this?
> Nurse: Carotid Angiogram
> Mrs. Smith: Sounds like the heart, I hope it's not the heart.
> Nurse: You sign this and we will give you a copy. Another thing, sign for a transfusion because you might have a blood transfusion.
> Mrs. Smith: I didn't think it was so bad
> Nurse: This is just in case, you know sometimes the doctor prepares everything just in case.

Picking up on cues and noticing anxiety, worry, or fear in a patient and being able to deal with it is another kind of communication skill that takes awareness of culture and language to fully develop.

In the area of miscommunications, sometimes the nurse and patient would completely mistake the other's meaning. For example; a non-native Asian nurse was talking to a non-native Middle-Eastern family member producing this miscommunication:

> Family member: His ears are hurting
> Nurse: Probably from the medication that's why it makes him foggy
> Family member: His ears are hurting
> Nurse: We'll see how he does without the oxygen (removes oxygen tubing)
> Family member: Inside his ears
> Nurse: We know, only for 24 hours

These nurses had been in their profession many years and were not novices; they had ranged from having seven to thirty years of experience working as nurses and had worked from four to twenty-five of those years in the U.S. Although one of the nurses reported that she had had four to five years of English instruction in the US, one nurse had only had six months instruction and three had had none at all. One of the hospitals had recently offered English language, instruction and two of the nurses had taken advantage of the classes (see demographics Table 9).

The native nurses had received all their training in the United States, ranging from 2-3 1/2 years of training. They were all native English speakers (See Table 10).

Table 9

Demographics of Non-native Nurses

Note: Read Across

Native Country:		Native Languages:
Philippines	2	Tagalog/Visayan
Taiwan	2	Mandarin
Korea	1	Mandarin/Taiwanese/ Japanese
		Mandarin/Foukin/Tagalog
		Korean

Country of Nurses Training:		Years of Nurses Training:	
Philippines	1	5 years	1
Philippines/Thailand	1	4 years	3
Taiwan	2	3 years	1
Korea	1		

Years of English Instruction In native country:		Years of English Instruction in US:	
9+ years	2	4-5 years	1
8 years	2	6 months	1
6 years	1	none	3

Years lived in the US:		Present Age:	
29 years	1	50 years	1
16 years	1	41 years	1
8 years	1	39 years	1
6 years	1	38 years	1
5 years	1	28 years	1

Lived in other English speaking countries:		If Yes: Country and length of time lived there:	
Yes	1	Canada	4 years
No	4		

Length of time worked as a nurse:		Years as a nurse in the US:	
30 years	1	25 years	1
16 years	1	16 years	1
15 years	1	7 years	1
12 years	1	5 years	1
7 years	1	4 years	1

Table 9 (cont.)

Length of time at this Hosp.	
22 years	1
16 years	1
3 years	1
2 years 9 mo.	1
1 year 6 mo.	1

Years in this area:	
15 years	1
5 years 6 mo.	1
3 years	1
2 years 9 mo.	1
1 year 6 mo.	1

English Instruction in this Hospital:	
Yes	2
No	3

Unit presently working on:	
Medical	2
Surgical	2
Direct observation	1

Other units worked in the past:	
Float	2
Orthopedics	1
Med/Surg/OB/OR	1
Labor room/Med/Surg	1

How much Instruction What kind of Instruction:
4 months 3 hours a week English for Hospital Personnel (Mt. San Antonio Jr. College program at the Hospital)

The native nurses had received all their training in the United States, ranging from 2-3 1/2 years of training. They were all native English speakers (See Table 10).

Such a conglomeration of information is interesting but it needs to be translated into easily understandable language. In the next section, the significance of this material will be discussed.

Table 10

Demographics of Native Nurses

Native country:		Native language:		Country of Training:	
USA	5	English	5	USA	5

Years of training:		AGE:		Years in the US:	
3 1/2	1	47	1	23	
2 1/2	1	42	1	12	
2	3	30	1	9	
		29	1	8	
		26	1	2 yr. 6 mo.	

Years at this hosp.		Work in what area:		How many years:	
18	1	Med/Surg	3	9	1
10	1	Orthopedics	1	5	1
9	1	Surgical A	1	4 yr. 8 mo	1
8	1			1	1
6 mo.	1			6 mo.	1

Areas worked previously in the hospital:	
No other	2
Surg/Ortho	1
ICU, CCU, DOU	1

Significance of the Data

Initially it was assumed that it was non-native nurses newly arrived in the United States that would require assistance communicating in the nurse-patient relationship. Through this study, even though it is not conclusive, it can be seen that non-native nurses who have lived and worked in the United States for many years also need instruction in communication. This came to light through observation; personal interviews or questionnaires would not have shown the same information. Directly after observing non-native nurses I would ask them if they felt

they had any communication problems; they would usually say they had problems on the telephone with doctors. None of the nurses I interviewed said that they felt they had difficulty with the nurse-patient relationship with native speaking patients. The non-native nurses did feel, however, that they had difficulty understanding and communicating with non-native patients.

Contrary to how the nurses felt about their abilities, through the observations I could clearly see that patients were sometimes frustrated, confused, or misunderstood. Why do nurses who have communication problems not recognize their own problems? This can be attributed to the fact that as the nurses work in the hospital for many years they become more confident, although they do not necessarily improve their communication skills.

Sunde (1986) reported that one nurse said that English instruction would have helped her initially but not after she had been working for some years. All the nurses interviewed after the observations stated that they would have benefitted from classes initially. This gives more credence for having classes for new non-native nurses, but it is clear that the nurses who may have been working for a number of years could also use some instruction. The nurses' own feelings about their language ability cannot be taken as accurate since they simply are not able to evaluate their own performances.

For the nurses who have been working for years there were notable individual differences. One nurse who had worked longer than any of the others had the most difficulty making herself clear to the patients, using terms that the patients understood, and establishing eye contact, particularly with male patients. On the other hand, one of the nurses who had worked a shorter time (and from the same country as the older nurse) had very little difficulty. She established rapport with the patients easily and used hospital slang and colloquial terms appropriately. This means that individual assessment and evaluation is crucial even for nurses who have lived and worked in the United States for some years.

Combining the results of my study, as small as they may be, with the results of Sunde (1986) and the recommendations of the special advisory committee of the California Board of Nursing (1990), there is little doubt that it is absolutely essential for non-native nurses (foreign trained) to have instruction in communication through specific English as a second language classes for nurses.

Another significant factor distilled from this study was that the functions that the two groups of nurses used were very similar. There was some variance on the number of times the functions were used, but there were many factors that could have contributed to that. Typically,

non-native nurses had shorter conversations with their patients, usually keeping their conversations business-like. This may be due to the fact that nurses and patients have different roles in different cultures. A nurse from Taiwan stated that nurses there would not want to be caught standing at a patient's bedside conversing, as a nurse caught conversing or chatting might get a reprimand from her supervisor.

Another factor affecting non-native nurses' communication style could be that communication as a therapeutic technique may not be emphasized as much as technical expertise. Most of the head nurses and supervisors I interviewed said that the non-native nurses were technically expert and for that reason usually worked in the Intensive care, Coronary care, or Direct Observation units. This concentration on technical ability might contribute to a lack of interest in improving their communication ability. As long as the nurse can effectively carry out the task; start the IV, insert the foley catheter, or change the bed, the degree of language ability does not seem to be important. This may have been reinforced by the hospitals, head nurses, and supervisors who have hired, retained, and promoted nurses based on their technical expertise. If the same interest was shown in the nurses' communication techniques as in their technical expertise they might be more motivated to improve.

The significance of the functions being used either more or less often may be accounted for by individual differences of each nurse. The function Socializing/ Talking was rated in the top six functions for non-native nurses because one nurse from the Philippines individually used that function 60 times. That was more than all the native nurses put together. This particular nurse was giving medication to all her patients, and the administration of this medication (by IV) took a few minutes. While the nurse was waiting, she would chat with the patients. This did not occur with any of the other nurses I observed, so the number is falsely elevated. Many more nurses need to be observed before the differences in the frequency or order of functions used could be said to be significant.

Limitations/Further Study

This study was limited by the number of nurses that could be observed. Many more hours of observation need to be completed before conclusive data can be obtained. There were also many variables, which will always be a problem in a study involving patients and nurses. More observers need to be involved and, ideally, the observations should be videotaped or recorded on audio tape.

During this study other topics presented themselves that would be very interesting for further study. One

issue is that of idioms or phrasal verbs in use in the hospital. Transcripts of native nurses showed that they used many phrasal verbs when communicating with their patients. It would be a worthwhile study to isolate and categorize the various phrasal verbs and their specialized meanings. Learning the phrasal verbs and idioms in use in the hospital could help the non-native nurses not only in understanding but also in oral production.

Another area of study could be to identify the functions used in specialized areas of nursing such as maternity nursing, the operating room, the emergency room, etc. Another alternative might be a study of non-verbal communication which would necessitate observations. Non-verbal communication is such a wide subject area including gestures, eye contact, silence, touch, etc., that it could be a complete study of its own.

Finally, patients' feelings about the communication of non-native nurses is an area that needs to be explored. Do patients find the nurses technically competent but cold and unfeeling? Do patients prefer non-native nurses because they are respectful and patient? These questions and many more should be answered by research.

Conclusion

This thesis has examined the nurse's role as a communicator in the hospital setting as it relates to the ability of the non-native (foreign-trained) nurse to speak English as a second language. The problems that non-native nurses have communicating with patients in the nurse-patient relationship have been noted and the importance of knowing the functions of the nurse-patient relationship enumerated. A survey which helped identify the prevalence of non-native nurses in the Los Angeles area was conducted with the result that it was found that 10 out of 14 hospitals had 20-25% non-native nurses.

This helped to give foundation to the fact that the question of non-native nurses in United State hospitals is an important one due to the fact that patients often come in contact with non-native nurses. A review of recent articles dealing with the subject of the communication difficulties of non-native nurses also showed the necessity of investigating this relationship and providing communicative help for non-native nurses.

The process of developing the solution to the communicative needs of the non-native nurse included using needs analysis (through observation in the hospital). After the relevance of needs analysis was demonstrated the model of other health care needs analyses and courses were

examined to provide a foundation for a proposed course in oral communication for non-native nurses.

The communicative functions for nurse-patient communication were identified preliminarily for the observation instrument through the use of a survey and by examining literature on the nurse-patient relationship. This led up to the direct observation of ten nurses in the hospital, five of whom were native nurses and five non-native nurses. These observations provided verbal data which were transcribed and scrutinized to provide a final list of 46 functions (from the native nurses) and problematic areas (from the non-native nurses).

Identifying the functions of the nurse-patient relationship as well as the problems that non-native nurses have communicating, led to the development of a course in oral communication for non-native nurses. In the following chapter a sample unit has been prepared based on the observations as well as the expressed needs of the non-native nurses, their head nurses, and supervisors. This sample unit can serve as a model for a course for non-native nurses in United States hospitals.

CHAPTER IV

SAMPLE COURSE:

IMPROVING ORAL COMMUNICATION FOR THE NON-NATIVE NURSE

Introduction for the Instructor

This course has been prepared to help the instructor meet the needs of non-native nurses working in United States hospitals, who trained in another country and speak English as a second language. It consists of six units designed to help nurses as professionals to improve their oral communication techniques in the context of the nurse-patient relationship. Unit one is written out in detail.

This course was developed after observation of non-native nurses working primarily in medical/surgical units in two Los Angeles area hospitals. It was designed to help nurses who have lived and worked in the United States for several years but continue to experience difficulties with oral communication. It could be adapted for nurses anticipating working in the United States or for orientation classes for nurses employed for the first time in a U.S. hospital. Any time the materials are used, they should be evaluated for appropriateness for the particular class of nurses being taught.

Communication is of the utmost importance to the effective nurse-patient relationship. In order to assist

non-native nurses in improving their communication skills, the instructor who is not a medical professional must have an understanding of the role of professional nurses. Basic Nursing books outline the nursing process, the importance of communication in nursing, and the therapeutic communication skills that nurses use to care for their patients (Taylor, Carol, and Lillis 1989; Potter and Perry 1987; Narrow and Bushle 1987; Sundberg 1989; Lindberg 1983).

Nurses are usually in control of communication with their patients; that is, they initiate the conversations, guide them, and bring them to a conclusion.

> In nursing, communication is often deliberately structured by the nurse because the conversation is central to the interaction, not incidental to it. Communication is often the primary concern because it may be the only tool by which you can relieve pain and suffering (Narrow and Buschle 1987, 124).

However, non-native nurses may not be conscious of what their real communication needs are. They often are not aware that they are not picking up patient cues or are not interacting in a therapeutic way.

It is important for the instructor to encourage the non-native speaking nurses to practice self-monitoring and self correction. Courses and classes provide input and practice for the nurses, but activities that enable the nurse to function independently outside of the classroom are very important in that they help bridge the gap between theory and reality.

Another issue to realize is that nurses who trained in other countries sometimes do not have the concept of continuing education that nurses have who are trained in the United States. They need to be motivated to learn and grow in their communication techniques so that they can continuously upgrade themselves as professionals.

This course focuses on the functions of nurse-patient communication while integrating the content of the nurse-patient relationship with practical language learning techniques found in the ESL classroom. The imagination, creativity, and expertise of the language teacher is vital in individualizing the material to accommodate the needs of each class of nurses. The instructor could also use direct observation, as well as interviews with head nurses, supervisors, and fellow nurses in order to be able to meet the distinctive requirements of any one particular group.

Each lesson consists of:

1. Information about nurse-patient communication
2. Pronunciation point
3. Function
4. Communication practice
5. Cultural issues

The activities within these sections vary in order to keep the course interesting to the nurses. Some of these activities include: small discussion groups, pair work and practice, lecturettes and note taking, listening tasks, role-plays, and cloze exercises. A variety of activities are available so that appropriate activities can be

selected by the individual instructor to meet the special needs of his/her class.

Suggested textbook:

Parkinson, Joy. 1978. English for Doctors and Nurses. Walton on Thames: Nelson. (Explanations and medical words and sentences. Sample dialogues. Grammar review in hospital English. Phrasal verbs, page 85).

Helpful texts to supplement these lessons:

Celce-Murcia, Marianne, and Dianne Larsen-Freeman. 1983. The Grammar Book. New York: Newbury House Publishers. (Phrasal verbs, chapter 20).

Claire, Elizabeth. 1990. An Indispensable Guide to Dangerous English! For Language Learners and Others 2d ed. Dundee, IL: Delta Systems. (Common terms for body parts and sexual functions, etc. Very explicit. To be used judiciously).

Karet, Julia, and Barbara Bader. n.d. English For Health Care Personnel Teacher's Manual produced by Mt. San Antonio College. Carl Perkins grant 87-0543 Model Vocation Education Skills 87-0543. (Short guide to pronunciation on pages 8+9).

Gilbert, Judy B. 1984. Clear Speech: Pronunciation and Listening Comprehension in American English. New York: Cambridge University Press. (Excellent text for pronunciation).

Narrow, Barbara, and Kay Buschle. 1987. Fundamentals of Nursing Practice. 2d ed. New York: John Wiley & Sons. (Pages 137-139 give valuable information about process recordings.)

Course Objectives:

To enhance the nurse-patient relationship and improve the quality of patient care:

1. by enabling non-native nurses to express themselves optimally as well as by increasing their understanding and comprehension of the needs of their patients, and

2. by motivating non-native nurses to use self-monitoring and self-correction techniques in an on-going effort to improve their communication skills with patients.

Sample Course Table of Contents

UNIT 1: The Nurse Communicating: Explaining

Objectives

A. Information about nurse-patient communication: Communication as sharing information

Activities

Activity 1. Introductions

Activity 2. Small group discussion

Activity 3. Lecture on communication

B. Pronunciation point

Activity 4. Intonation practice

C. Function: Explaining

Activity 5. Discuss explaining

Activity 6. Dialogue

D. Communication practice

Activity 7. Role-play

Activity 8. Process recordings as a class

Activity 9. Process recordings for the individual

Activity 10. Mix and match phrasal verbs

E. Cultural issues

Activity 11. Interacting with eye-contact

UNIT 2: The Nurse Communicating: Commenting

Information about nurse-patient communication:
Non-verbal communication

Pronunciation point:

1. Stress
2. Pronunciation of medical terminology

Function: Commenting

Communication practice:

1. Talking on the telephone
2. Hospital slang and abbreviations

Cultural issues:

1. How different cultures look at death

UNIT 3: The Nurse Communicating: Expressing Intention

Information about nurse-patient communication:
Barriers to communication

Pronunciation point: Pitch (review stress and intonation)

Function: Expressing intention

Communication practice:

1. Colloquialisms (common words for bathroom functions)
2. Help in expressing feelings

Cultural issues: How different cultures look at family

UNIT 4: The Nurse Communicating: Direct Questioning

Information about nurse-patient communication:
Picking up on cues/feedback

Pronunciation point: Intonation for questions

Function: Direct Questioning

Communication practice:

1. Idioms
2. Talking on the telephone: adjusting to other accents

Cultural issues: How different cultures look at health

UNIT 5: The Nurse Communicating: Directing/Instructing

Information about nurse-patient communication:
Alternate ways of getting information

Pronunciation point: Quality/volume/stress

Function: Eliciting information

Communication practice:

1. More idioms
2. Attitudes

Cultural issues: How different cultures look at sickness

UNIT 6: The Nurse Communicating: Directing/Instructing

Information about nurse-patient communication:
How to get things done (verbally and non-verbally)

Pronunciation point: Tone of voice (voice quality-loudness)

Function: Directing/Instructing

Communication practice:

1. Expressing feelings
2. Medical terminology

Cultural issues: Nursing (self-image/assertiveness)

Unit 1:

The Nurse Communicating: Explaining

Objectives:

1. The student will be able to introduce his/her self in a culturally appropriate way.
2. The student will demonstrate culturally appropriate use of eye-contact to use with patients and colleagues.
3. The student will complete a process recording and demonstrate ability with self-monitoring techniques.
4. The student will discuss, practice, and be able to demonstrate "explaining" in a nurse-patient situation.

A. Information about nurse patient communication:

Communication as sharing information

Activities

Activity 1. Introductions.

Rationale: To practice making introductions to patients in the hospital, and to help the instructor and students to become acquainted with one another.

Materials: Handout #1 Page 85. Teacher-prepared video or slide tape presentation.

Procedure: Instructor introduces her/him self and/or a colleague or aide in order to model the introduction style. Explain and demonstrate the handout or show a prepared video or slide tape presentation to the class. Have the students introduce one another as if to a patient. In this situation they have cared for the patient for five days and the patient is anxious because a different nurse will be taking care of her. Placing the students in pairs, circulate around the room listening to the interactions.

Have a few of the students demonstrate for the class or, if the class is small, have all the paired partners introduce one another to the class in this fashion. A sample dialogue to model could be: "Mrs. Smith this is Elvia Francisco. She will be your nurse tomorrow on my day off. She is from the Philippines originally, but she's lived in the United States for eight years now. She's worked here at General Hospital for five years. Elvia's husband works here too as a pharmacist. They have two little boys. She will take very good care of you."

Activity 2. Small group discussion.

Rationale: To further set the group at ease, encourage participation, and help focus on the topic. To increase students' awareness of different concepts of communication.

Materials: Handout #2 page 86.

Procedure: After dividing the participants into small groups, Handout #2 can be given to each group. Each group

will discuss the situation and answer the questions. Appoint one person to report to the entire class.

Activity 3. Lecture on Communication.

Rationale: The lecture format for nursing education is universal. It will be familiar to the participants and can help to promote interest in the subject and the course. It will also serve to provide the content base for the remainder of the course and additionally, motivate the participants to improve their communication skills. It provides listening practice and, if the worksheets are used, reading and writing practice as well.

Materials: Handout #3 page 87. Teacher-prepared transparency for the overhead projector.

Procedure: Photocopy enough handouts so that each student has one. If possible, prepare a transparency to be filled out while giving the lecture. This will slow down the lecture as well as help the students with words they may not be familiar with. An alternate procedure would be to give the lecture first without the handouts and then repeat the lecture with the handouts. Go back over the lecture making sure all the students were able to fill in the blanks. Discuss words or terms that remain unclear to the students.

A Sample Lecture

Communication can be defined as sharing information. Telling a patient that he will be having an x-ray and he will not be able to eat breakfast, is sharing information. Communication is more than just giving straight information; it is also the creating and sending of a message.

In order to create and send a message, two people must be involved. Communication goes back and forth between people. When the nurse tells the patient he is going to have an x-ray and he will not be able to eat breakfast tomorrow; she has shared information, she has created and sent a message. When the patient asks the nurse if he can still have his pills that he usually takes with his breakfast, he is showing that he heard the message and is creating and sending a message in return. That is communication, the process in which meanings are exchanged between or among persons.

The people who are involved in communication must have a relationship. One person alone, in isolation, does not communicate. Just being in the same room with someone, or standing next to someone does not mean there will be communication. Often two or more people may be standing in line at the grocery store, or standing in line for the bus, but they do not communicate just by being there. True communication requires a relationship between two or more people.

The heart of nursing is the relationship between the nurse and the patient. This relationship requires communication. Because interaction between persons is the heart of nursing, nurses need a sound knowledge of the principles of communication. Effective communication helps nurses to build trusting relationships between themselves and their clients

Through these lessons on communication you may learn some communication skills that are new to you. If you are familiar with these skills, you can work on improving them in your second language, English. Improving your communication skills is one of the most important ways you can improve patient care.

Some of the topics we will cover in this course are paralanguage, non-verbal communication, barriers to communication, and therapeutic communication.

Paralanguage means those elements of communication that are beside, next to, or alongside, spoken verbal communication. Paralanguage includes the pattern of speech, or intonation; the speed that words are spoken, or the rate; the high or low tone of voice, or pitch; the loudness or softness of a voice, or volume; and the ability of a person to speak with

few repetitions, hesitations, false starts, etc., or fluency.

Intonation is the tune of what we say. It is the rising and falling sounds that English speakers use to pronounce the syllables that make up our speech. Listen to the tune of this sentence. "Good morning, Mrs. Jones, how are you today?" That tune is produced by making a higher sound on the emphasized syllables and lower sounds on syllables that are not emphasized. This takes practice to hear and imitate.

B. Pronunciation point

Activity 4. Intonation practice.

Rationale: To familiarize the students with intonation as it relates to everyday conversations they might have.

Materials: Handout #4 page 89.

Procedure: This is a long dialogue based on authentic conversation. All or part of it can be used to demonstrate intonation by drawing lines on the transcript indicating a rising or falling tone, and the class can practice the intonations indicated. It can be helpful if the instructor indicates if the intonation rises or falls by directing with an exaggerated hand motion. The entire class can repeat the lines or phrases together, or groups within the class can take parts of the dialogue to repeat out loud. Encourage the class to keep time with the rhythm, and to exaggerate the sounds at first in order to better hear the differences between rising and falling intonation.

Note to the instructor: The next section deals with a language communication function that nurses use daily: explaining. The first activity focuses the class's

attention on what is included in a good explanation, and the second activity models the use of an explanation.

C. Function: Explaining

Activity 5. Discussion.

Rationale: To provide a basis for practicing a good explaining technique. To allow the nurses to focus on explaining functions they may use daily.

Materials: Group discussion may be facilitated by writing key words or ideas on the board or flip chart.

Procedure: Lead a group discussion on what is a good explanation. Have several examples such as, "Your lunch is late because the diet trays came 15 minutes later than usual" or "We weren't able to schedule the test for today, Mrs. Jones. You're on the schedule for 8 A.M. tomorrow." Point out the essentials of a good explanation: it must be truthful and satisfying to the hearer. When the patient asks additional questions, it means the person is not yet satisfied and wants more information.

Activity 6. Dialogue.

Rationale: To introduce the function of explaining. To use as an example for pointing out intonation in authentic speech. To serve as a model for the nurses' own interactions when later they role-play explaining situations.

Materials: Handout #4 page 89. Videotape if desired. Teacher-prepared transparency.

Procedure: Model the dialogue by having two persons demonstrate it in front of the class, or have it video-taped beforehand and play it for the class, repeating it as many times as necessary. The dialogue can be written on an overhead transparency and on handouts passed out to the class. Instruct the class to mark their handouts for intonation as you read (as many times as necessary) the dialogue, indicating the intonation by your voice and hand motions. With participation from the class find the words that take stress. The dialogue can be practiced by the entire class with the instructor, progressing to half of the class practicing with the other half of the class, row by row, and eventually pair practice. During pair practice the instructor can select one or two pairs to demonstrate for the entire class.

D. Communication practice

Activity 7. Role-play.

Rationale: To assist the participants to put into practice what they have learned, and enable the instructor to evaluate the communication difficulties of the individual participants.

Materials: Handout #5 page 90. Tape recording equipment or videotaping equipment, if desired.

Procedure: Demonstrate a role-play for the students with the assistance of a colleague or aide. For instance, one person can be the nurse who is explaining to the "patient,"

who wants her mother, that no one is admitted to the labor room except the father of the baby. Another example could be a nurse explaining to an anxious patient that his/her surgery was canceled due to an emergency.

Divide the class into pairs, and give each pair one of the four role-plays on handout #5. Direct the students to discuss the situation and take turns acting out the parts. Listen to the groups and select one or two pairs to perform in front of the class. Model the role-plays if necessary.

Audiotaping or videotaping of the role-plays could be very useful for increasing the participants' awareness of their communication problems or weaknesses. The audiotapes or videotapes could be reviewed privately by the teacher with each student or generally with the entire class. An alternate way of using the role-plays would be to practice them in class, videotape them outside of class, and review them together as a class. When reviewing the role-plays, encourage full explanations. Comment and compliment explanations that are complete and satisfying. By asking questions and modeling, supplement poorer quality role plays in order to reinforce good explanation technique.

Activity 8. Process recordings as a class.

A process recording is a device used to teach nursing students communication techniques. It involves taking an actual conversation they have had with a patient and analyzing it in three sections. The student writes down

what the patient said and did, what the student him/herself thought and felt, and what the student actually said and did. This enables the student to increase his/her awareness of what happens during conversations and to be able to plan changes for the future.

Rationale: Many non-native nurses are not aware of their communication styles or that they may not be meeting their patients' communication needs. Process recordings are used in some U.S. nursing schools in order to help the nursing students develop awareness of the effectiveness of their communication. This process will help the nurses use self-monitoring techniques, sensitizing them to their own communications with patients.

Materials: Handout #6 page 91. Handout #7 page 92. Handout #8 page 94. Videotaping equipment if desired. Teacher-made transparency of the process recording sheet.

Procedure: After briefly explaining the purpose of process recordings, introduce the dialogue (handout #7) by acting it out with a colleague or aide, or have it videotaped and shown on the video. The conversation is adapted from an actual interaction between a non-native nurse and a patient. After the conversation is seen or listened to, the instructor can demonstrate a process recording using the dialogue as a sample conversation. The process recording sheet (handout #6) can be made into a

transparency and the whole class can participate in analyzing the conversation utilizing handout #8.

Activity 9. Process recording for the individual.

Rationale: To enable the student to utilize this technique for her/himself as a self-monitoring device.

Materials: Handout #6 page 91. Evaluation guidelines Handout #8 page 94.

Procedure: After doing the process recording of handout #7 as a class, ask the participants to record a conversation that they actually have had with a patient using handout #6. The completed handout is to be turned in to the instructor at the next class. It may be helpful to tell them to do the recording on the next shift that they work and to record the conversation they have directly before break time. This will help them to keep from avoiding the assignment and will also help narrow down the possibilities. Usually the process recordings are self-analyzed, and over the next six units the participants will work toward that goal. For this unit the instructor will write comments on the papers in order to provide a model for the students to follow. (See Narrow and Buschle 1987 in the list of helpful texts on page 66 for a good resource for process recordings.)

Activity 10. Mix and match phrasal verbs.

Rationale: In examining the transcripts of five native speakers, idioms were rare, but phrasal verbs were common.

Some of the phrases may be familiar to the nurses, and some may be new.

Materials: Handout #9 page 95.

Procedure: Phrasal verbs are described as a verb followed by either a preposition, an adverb, or possibly a combination of the two, e.g., "Don't cut down on your proteins". "Don't let the oxygen run out". "I will look into that." "I put the poisoning down to that shellfish I ate last night (Parkinson 1978, 85, Celce-Murcia 1983, 265). For additional information on phrasal verbs see Celce-Murcia 1983 in the list of helpful texts on page 66. The phrasal verbs can then be presented in a mix and match exercise. The class can be divided into pairs to try to match the phrases with the definitions. The entire class could then pool their answers and fill out the sheet with the instructor on the overhead projector. There could be a lot of discussion about this subject since some of the phrasal verbs have several meanings.

Key to the matching exercise (Handout #9)

1. F	9. B
2. O	10. K
3. G	11. C
4. P	12. D
5. H	13. M
6. I	14. E
7. A	15. N
8. J	

Phrasal Verbs: Definition key

1. Check on I'll check on your shot.	Investigate-find out about
2. Going on There is some bleeding going on.	Happening
3. Get up Can you get up by yourself?	Leave bed
4. Come up The doctor will come up and take a look at you.	Arrive from another location
5. Roll over Please roll over for me.	Turn to the side
6. Sit up I want you to sit up in the chair	Sit erect
7. Get out of He needs to get out of bed today.	Leave (bed, bath, car)
8. Run in I need to run in to room 305.	Quick visit
9. Run out of I had to run out of the meeting so I wouldn't be late for work.	Quick departure
10. Run out of We are about to run out of syringes again.	Come to an end (depleted)
11. Lift up I'm going to lift you up now.	Re-position
12. Closed up It's much better today, it's almost closed up.	Healed (wound)
13. Take down Gary will take you down in the wheelchair.	Transport from one location to another
14. Go out You have to go out in the wheelchair.	Leave
15. Look at He'll look at your incision.	Examine

E. Cultural issues

Activity 11. Interacting with eye-contact.

Rationale: To graphically call to the attention of the nurses the importance of eye-contact in American culture. To help the nurses understand how Americans feel about people who do not make eye-contact or who slide away from eye-contact. To help nurses understand American introduction styles.

Material: A slide tape presentation, or video presentation, or as many pictures as possible. Colleagues or aides could also be used.

Procedure: Prepare a graphic illustration of Americans interacting, particularly when introducing themselves to others. Concentrate on showing eye-contact and facial expressions.

Possible introductory situations include:

1. a nurse introducing herself to a patient
2. a nurse introducing himself to a doctor
3. a doctor introducing herself to a patient
4. a doctor introducing himself to a nurse
5. a nurse introducing herself to a family member
6. a nurse introducing himself to a fellow nurse at a meeting
7. a nurse introducing herself to other employees in the cafeteria
8. a nurse introducing himself to fellow employees on the elevator.

Particularly point out the fact that when Americans say their names they expect to hear a name as a response. This is not the case in many cultures. For instance, when a nurse says "Hi, I'm Amy, I'm Sam's nurse" to a family member, she expects to hear "Hi, Amy, I'm Fred, Sam's brother" in reply. This exchange is often completed with a firm handshake.

Have the class get into small groups and discuss the presentation. Have them find 3-5 common things that they noticed in the introductions or interactions they saw. Divide the class into pairs and have them create their own introductions or interactions and practice them. Select a few pairs to demonstrate their introductions or interactions in front of the class.

Handout #1 (Introduction)

You have had a patient for five days and you have become very close. Your patient is worried about having a different nurse tomorrow on your day off. You have the opportunity to introduce your patient's new nurse to her. Get with another person and find out the following information. Practice introducing your partner to your patient using the information.

What is her/his name?_____

What is her/his native country_____

What is her/ his native language_____

How many years has she/he lived in the USA?_____

How many years has she/he worked at this hospital?_____

Is she/he married or single?_____

How many children does she/he have?_____

Handout #2 (Small group discussion)

Read the following conversation.

Family member: His ears are hurting.
Nurse: Probably from the medication. That's why it makes him foggy.
Family member: His ears are hurting.
Nurse: We'll see how he does without the oxygen (removes oxygen tubing).
Family member: Inside his ears.
Nurse: We know, only for 24 hours.

In a small group answer these questions. One person will tell the whole class your group's answers.

1). What is the problem between the nurse and the family member in this conversation?

2). How could the nurse have responded differently to the family member? Give two examples.

3). How could this conversation affect the patient's care?

4). Give one example from your own experiences of a miscommunication that actually happened between a nurse and a patient.

Handout #3 (communication)

A Sample Lecture:

1. Communication can be defined as sharing _____. Communication is more than just giving straight information; it is also the creating and _____ of a message.

2. In order to create and send a message, two people must be involved. Communication goes back and forth between _____.

That is communication, the process in which _____ are exchanged between or among persons.

3. The people who are involved in communication must have a relationship. One person alone, in _____, does not communicate.

True communication requires a _____ between two or more people.

4. The heart of nursing is the relationship between the nurse and the patient and this relationship requires communication.

Because _____ between persons is the heart of nursing, nurses need a sound knowledge of the principles of communication.

5. Improving your _____ skills is one of the most important ways you can improve patient care.

6. Some of the topics we will cover in this course are:

   a. Paralanguage

   b. Non-verbal communication

   c. Barriers to communication

   d. Therapeutic communication

Paralanguage includes:

1. The pattern of speech, or _____.

2. The speed that words are spoken, or _____.

3. The high or low tone of a person's voice,

or _____.

4. The loudness or softness of a persons voice,

or _____.

5. The ability of a person to speak with few repetitions, hesitations, false starts, etc., or _____.

6. Intonation is the _____ of what we say. It is the rising and falling patterns that English speakers use to pronounce the syllables that make up our speech.

Handout #4 (Dialogue)

Instructions: As this dialogue is read out loud, mark the words that are stressed. Practice reading and saying this dialogue with the class.

Situation: Mrs. Jones is a new admit for surgery, and her nurse Mary has just helped her get into bed.

Mrs. Jones: What time is my surgery?

Mary: I'm not sure yet. After I've admitted you I'll look over your chart, and then I'll be able to explain everything to you.

Mrs. Jones: Will I be able to have anything for pain?

Mary: Everything is taken care of: pain pills, sleeping pill, laxatives, everything.

Mrs. Jones: What is this bar over my head?

Mary: This is an orthopedic floor, this bar is to help the patients pull themselves up in bed.

Mrs. Jones: Why am I on this floor?

Mary: The fifth floor is closed now, so all the surgery patients are here on the third floor. Ok, I'm going to go check your chart now, and then I'll get back to you about the time of your surgery. See you later.

Handout #5 (Role-Play)

Instructions: Read the following situation with your partner. Take turns acting out the part of the patient and the nurse.

1. Your patient was admitted early this morning but your patient still has not received any medication or a diet tray. The doctor has not come in, written any orders, or returned your calls, you expect the doctor will be in after lunch. The patient asks you why he hasn't gotten anything to eat.

2. Your surgery patient's IV has infiltrated (it's out) but the patient is still supposed to be receiving morphine IV for pain. Another nurse has tried twice to restart your patients IV and your patient is crying and asking you not to re-start the IV. The patient is very elderly and has small deep veins.

3. Your patient has been waiting NPO (nothing by mouth) for an important x-ray procedure. When you call x-ray they tell you they will be able to do the procedure in a half hour. Your patient is asking for something to eat.

4. Your patient is taking a medication (pyridium) that turns the urine a deep orange color. Your patient is unaware of this and is concerned about the color of his urine.

Handout #6 (Process Recording Sheet)

You will need to write down a conversation that you have had with a patient. Write it down as soon after it happens as possible. The conversation should be about 2-3 minutes in length. Use the columns to write down what the patient said and did, what you thought and felt, and what you then said or did.

What the patient did	What I thought and felt	What I said and did

Handout #7 (Conversation for the process recording)

Situation: The nurse is told by the supervisor to go get a surgical consent signed.

Nurse: Hi

Mrs. Smith: Hi

Nurse: Tomorrow you're going to surgery. They will do a Carotid Angiogram.

Mrs. Smith: What time will it be?

Nurse: I will check the surgery schedule.

Mrs. Smith: Will I eat breakfast tomorrow?

Nurse: No, no, don't eat breakfast--no, maybe after, not before. You might vomit if they do this procedure.

Mrs. Smith: What time is surgery?

Nurse: I am going to check later, but now they don't have the surgery schedule. The supervisor is still working on it. I'm going to ask you to sign this beside the x.

Mrs. Smith: What is this? (She is looking at the consent form).

Nurse: Carotid Angiogram

Mrs. Smith: Sounds like the heart; I hope it's not the heart.

Nurse: You sign this, and we will give you a copy. Another thing, sign for a transfusion because you might have a blood transfusion.

Mrs. Smith: I didn't think it was so bad.

Nurse: This is just in case; you know sometimes the doctor. prepares everything just in case.

Handout #8 (Evaluation guidelines)

Was the nurse's response prompted by the patient's words or actions?

Was the nurse listening and observing?

Are there any missed or ignored cues?

Could the patient hear the nurse? Were the patient's words and actions in response to what the nurse said or did?

Were the nurse's thoughts and feelings appropriate to what she had seen and heard, or did she fail to give proper attention?

Is there a flow of ideas and feelings between the patient and the nurse, or is the interaction broken up?

The content can be evaluated by looking at each response for the level of sensitivity.

A sensitive response is understanding, accepting, and helpful.
A neutral response is neither hurtful nor very helpful.
A nonsensitive response lacks understanding and is hurtful and rejecting (Narrow and Buschle 1987, page 138).

Handout #9 (Mix and Match)

Instructions: Match the letter with the correct number. Number one will be done for you.

_F_1. Check on
I'll check on your shot.

___2. Going on
There is some bleeding going on.

___3. Get up
Can you get up by yourself?

___4. Come up
The doctor will come up and examine you.

___5. Roll over
Please roll over for me.

___6. Sit up
I want you to sit up in the chair

___7. Get out of
He needs to get out of bed today.

___8. Run in
I need to run in to room 305.

___9. Run out of
I had to run out of the meeting so I wouldn't be late for work.

___10. Run out of (depleted)
We are about to run out of syringes again.

___11. Lift up
I'm going to lift you up now.

___12. Closed up
It's much better today; it's almost closed up.

___13. Take down
Gary will take you down in the wheelchair.

a. Leave (bed, bath)

b. A quick departure

c. Re-position

d. Healed (wound)

e. Leave this place for another place

f. Investigate-find out about

g. Leave the bed or chair and walk

h. turn to the side

i. Sit erect

j. A quick visit

k. Come to an end

m. Transport from one location to another

n. Examine

___14. Go out
You have to <u>go</u> <u>out</u>
in the wheelchair.

___15. Look at
He'll <u>look</u> <u>at</u> your incision.

o. Happening

p. Arrive from another location

Notes

1. The term, registry nurse, refers to a nurse that is employed by an outside company. The job of this company is to send nurses to hospitals only when they are needed and requested by the hospital. A registry nurse is not an employee of any one particular hospital.

2. Both of the nurses who refused to answer the questionnaire had heard the explanation. Both had heavy foreign accents (different from each other).

3. It was interesting that many of the hospitals (in the hospital survey) commented that they "couldn't" give language tests to applicants because they were afraid it would be discriminatory. Two people expressed the opinion that if a test were given to one nurse it would have to be given to all, even native speaking nurses. Powers and Stansfield (1985) report that at least one state is already testing nurses. Wisconsin requires its FNGs to pass the Job Simulation Test of English Language Proficiency.

APPENDIX A

HOSPITAL SURVEY

I am a Registered Nurse currently working on my M.A. in Teaching English as a Second Language. I am interested in finding out what difficulties non-native speaking nurses have with the nurse-patient relationship. I want to be able to design lessons that would help them improve their language ability in order to make their nurse-patient relationship more effective. I would like to have some information about the non-native speaking nurses in your hospital. I am interested in those nurses that speak English as a Second language and did their nurses training in another country. Could I ask you a few questions, it will take about 5 minutes of your time.

1. How many beds in your hospital?

2. How many RNs do you employ at your hospital?

3. How many RNs do you have that are non-native speakers? (Approximately if necessary)

4. What areas or units in the hospital have the highest percentage of non-native speaking nurses?

Intensive care____ Emergency room____ Step down units___

General Med___ Maternity ____ Nursery____ Pediatrics___

Outpatient____ Other_____

5. What English proficiency is required for nurses to be hired?

a. Do you require a certain amount of years of prior study of English? Yes/No ____

b. Scores on oral or written test? Yes/No ____
If yes what tests_____ what score_____

c. Ability to fill out application and pass an oral interview.

d. Other_____

6. Are any language tests given by the hospital? Yes/No ____

If yes what kind _____

7. Is any English language instruction provided by the hospital? Yes/No ____

If Yes :	Class	When	#hrs	eval.	other
a. Conversational					
b. Hospital medical abbrev.					
c. Interpersonal communication					
d. American culture					
e. Nurse-patient relationship					
f. Orientation for non-native speakers					
g. Other					

8. Do you think your hospital would be interested in being involved in research in the area of non-native speaking nurses and the nurse-patient relationship?

APPENDIX B

LANGUAGE FUNCTION FOR T-LEVEL

1. Imparting and seeking factual information

1.1 identifying
1.2 reporting (including describing and narrating)
1.3 correcting
1.4 asking.

2. Expressing and finding out intellectual attitudes

2.1 expressing agreement and disagreement
2.2 inquiring about agreement or disagreement
2.3 denying something
2.4 accepting an offer or invitation
2.5 declining an offer or invitation
2.6 inquiring whether offer or invitation is accepted or declined
2.7 offering to do something
2.8 stating whether one remembers or has forgotten something or someone
2.9 inquiring whether someone remembers or has forgotten something or someone
2.10 expressing whether something is considered possible or impossible
2.11 inquiring whether something is considered possible or impossible
2.12 expressing capability and incapability
2.13 inquiring about capability or incapability
2.14 expressing whether something is considered a logical conclusion (deduction)
2.15 inquiring whether something is considered a logical conclusion (deduction)
2.16 expressing how certain/uncertain one is of something
2.17 inquiring how certain/uncertain others are of something
2.18 expressing one is/is not obliged to do something
2.19 inquiring whether one is obliged to do something
2.20 expressing others are/are not obliged to do something
2.21 inquiring whether others are obliged to do something
2.22 giving and seeking permission to do something
2.23 inquiring whether others have permission to do something
2.24 stating that permission is withheld.

3. Expressing and finding out emotional attitudes

3.1 expressing pleasure, liking

3.2 expressing displeasure, dislike
3.3 inquiring about pleasure, liking, displeasure, dislike
3.4 expressing surprise
3.5 expressing hope
3.6 expressing satisfaction
3.7 expressing dissatisfaction
3.8 expressing disappointment
3.10 expressing fear or worry
3.11 inquiring about satisfaction or dissatisfaction
3.12 expressing preference
3.13 inquiring about preference
3.14 expressing gratitude
3.15 expressing sympathy
3.16 expressing intention
3.17 inquiring about intention
3.18 expressing want, desire
3.19 inquiring about want, desire.

4. Expressing and finding out moral attitudes

4.1 apologizing
4.2 granting forgiveness
4.3 expressing approval
4.4 expressing disapproval
4.5 inquiring about approval or disapproval
4.6 expressing appreciation
4.7 expressing regret
4.8 expressing indifference.

5. Getting things done (suasion)

5.1 suggesting a course of action (including the speaker)
5.2 requesting others to do something
5.3 inviting others to do something
5.4 advising others to do something
5.5 warning others to take care or to refrain from doing something
5.6 instructing or directing others to do something.

6. Socializing

6.1 greeting people
6.2 when meeting people
6.3 introducing people and being introduced
6.4 taking leave
6.5 attracting attention
6.6 proposing a toast
6.7 beginning a meal.

APPENDIX C

SURVEY FOR REGISTERED NURSES

The following are general language functions. These describe what individuals do with their language. When a nurse enters a room and says, "Hi" she is using her language to "6.1 greet people." Please indicate with an x the category that best describes how you use the function in your contacts with patients. After you have finished please go back and circle the numbers you feel are the most important in the nurse-patient relationship.

For example:

I use this Function in every contact with my patients	I use this in some of my contacts with my patients	Hardly ever use this in my contacts with my patients	
x			Example: 6.1 to greet people
		x	6.6 propose a toast
			Survey: (IMPARTING AND SEEKING FACTUAL INFORMATION)
			1.1 identifying
			1.2 reporting (including describing and narrating)
			1.3 correcting
			1.4 asking
			2.1 expressing agreement and disagreement
			2.2 inquiring about agreement or disagreement
			2.3 denying something

I use this Function in <u>every</u> contact with my patients	I use this in <u>some</u> of my contacts with my patients	<u>Hardly ever</u> use this in my contacts with my patients	
			2.4 accepting an offer or invitation 2.5 declining an offer or invitation 2.6 inquiring whether offer or invitation is accepted or declined 2.7 offering to do something 2.8 stating whether one remembers or has forgotten something or someone 2.9 inquiring whether someone remembers or has forgotten something or someone 2.10 expressing whether something is considered possible or impossible 2.11 inquiring whether something is considered possible or impossible 2.12 expressing capability and incapability 2.13 inquiring about capability or incapability 2.14 expressing whether something is considered a logical conclusion (deduction) 2.15 expressing how certain/uncertain one is of

I use this Function in <u>every</u> contact with my patients	I use this in <u>some</u> of my contacts with my patients	<u>Hardly ever</u> use this in my contacts with my patients	
			2.16 expressing how certain/uncertain one is of something 2.17 inquiring how certain/uncertain others are of something 2.18 expressing one is/is not obliged to do something 2.19 inquiring whether one is obliged to do something 2.20 expressing others are/are not obliged to do something 2.22 giving and seeking permission to do something 2.23 inquiring whether others have permission to do something 2.24 stating that permission is withheld. (EXPRESSING AND FINDING OUT EMOTIONAL ATTITUDES) 3.2 expressing displeasure, dislike 3.3 inquiring about pleasure, displeasure, likes, dislikes 3.4 expressing surprise 3.5 expressing hope 3.6 expressing

I use this Function in <u>every</u> contact with my patients	I use this in <u>some</u> of my contacts with my patients	<u>Hardly ever</u> use this in my contacts with my patients	
			3.8 inquiring about satisfaction or dissatisfaction
			3.9 expressing disappointment
			3.10 expressing fear or worry
			3.11 inquiring about fear or worry
			3.12 expressing preference
			3.13 inquiring about preference
			3.14 expressing gratitude
			3.15 expressing sympathy
			3.16 expressing intention
			3.17 inquiring about intention
			3.18 expressing want, desire
			3.19 inquiring about want, desire
			(EXPRESSING AND FINDING OUT MORAL ATTITUDES)
			4.1 apologizing
			4.2 granting forgiveness
			4.3 expressing approval
			4.4 expressing disapproval

I use this Function in <u>every</u> contact with my patients	I use this in <u>some</u> of my contacts with my patients	<u>Hardly ever</u> use this in my contacts with my patients	
			4.6 expressing appreciation 4.7 expressing regret 4.8 expressing indifference. (GETTING THINGS DONE) 5.1 suggesting a course of action (including the speaker) 5.2 requesting others to do something 5.3 inviting others to do something 5.4 advising others to do something 5.5 warning others to take care of or refrain from doing something 5.6 instructing or directing others to do something. (SOCIALIZING) 6.1 greeting people 6.2 meeting people 6.3 introducing people and being introduced 6.4 taking leave 6.5 attracting attention 6.6 proposing a toast

APPENDIX D

PROPOSAL

Non-Native Speaking RNs in Hospitals in the United States: Nurse-Patient Communication

Recently in the United States non-native speaking nurses have become common in many hospitals. I conducted a telephone survey of 14 local (Pasadena, Alhambra, Montebello, Glendale, Burbank, and greater Los Angeles) hospitals. Ten hospitals out of fourteen stated they believed they probably had more than 20-25% non-native speaking nurses. That means that patients will frequently come in contact with non-native speaking nurses.

Although much has been said about foreign nurses and their working relationship with native nurses (Dudas and Dzik 1971; Davitz, Davitz, and Sameshima 1976; Arbeiter 1988), there is very little written about the non-native speaker in the nurse-patient relationship. What has been written indicates that the non-native speaking nurse has real difficulties in this area (Allen 1980; Barnes 1980; Sunde 1986). It is essential that non-native speaking nurses communicate effectively with patients and that they have specialized instruction that focuses on their particular language needs.

In my thesis I will find the communicative functions (what the nurses actually do with the language) through the use of a literature review of nurse-patient communication

and a target situation analysis (observation of both native speakers and non-native speakers in the actual hospital setting).

After identifying the communicative functions I will prepare functional, communicative materials for non-native speaker nurses in the area of nurse-patient communication. This will be in the form of a sample lesson(s).

Although the term "foreign nurse" is often used, for the purposes of my study, I will refer to "non-native" speaking nurses. I will identify a non-native speaking nurse as a nurse who trained in another country and speaks English as a second language.

I will observe 10 different nurses at two different hospitals. At each location I will observe 2 native speaking nurses and 3 non-native speaking nurses for 4 hours each. If two locations are not available I will observe ten nurses in one location. If permission is granted I would like to observe during the day shift from 8-12 to provide continuity. I would request native speaking nurses that are considered by patients or staff to have exceptionally good nurse-patient communication skills (by recommendation of a supervisor, patient letters, or praise received, etc.).

I would like to observe non-native speaking nurses who are working in the hospital as their first job in the U.S,

and have been at the hospital for less than a year. This is important as the results of my research could be developed for use in orientation or in a workshop for new employees before prolonged contact with patients. I assume that new employees will have more difficulty with the nurse-patient relationship than long-term employees. However, I am willing to work with the hospital on researching the problems of their non-native speaking nurses who have been in the U.S. for longer periods or worked in other locations. This would give the picture of language problems of long-term non-native speaking RNs.

Ideally, audio and video taping would be used for a study of this kind (Burton, Candlin, and Leather 1976). However, it is impractical in a hospital study. I will attempt to counteract this difficulty by identifying as many functions as possible prior to observation by reviewing the literature as well as by giving a small survey to five native speaking nurses.

In the 1970's there was a great deal of interest in English for Specific Purposes, which included English for medical personnel. A well-known study was done by researchers in England identifying the speech functions of doctors, focusing on the doctor-patient communication in the emergency room. (Burton, et al. 1976). Another study was also conducted in England looking into dentist-patient communication (Coleman 1985). I have not discovered any

studies specifically dealing with nurse-patient communication. A study of nurse-patient communication will generate valuable information that can help those in the field of English as a second language to develop materials and curriculum, and those in the medical field to tackle the job of helping the non-native speaking nurse improve in nurse-patient communication.

The Hypothesis:

Non-native speaking nurses have difficulty with nurse-patient communication and they require specialized instruction that focuses on their particular language needs.

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APPENDIX E

INFORMED CONSENT

Non-Native Speaking RNs in hospitals in the United States: Nurse-Patient Communication.

Nurse-patient communication is very important in the hospital setting. The purpose of this study is to identify the communicative functions of the nurse-patient relationship. These functions are what nurses actually do with the language, e.g., advising, informing, comforting, etc. The importance of identifying these functions is in order to design a lesson or lessons that will assist non-native speaker nurses to improve their nurse-patient relationship.

There are no known risks associated with this study, and there is no compensation for participating. Benefits that may result for participants are unknown at this time. Participants can receive the results of the study if they so desire.

In participating in this study you will be observed in the hospital during your routine contact with your patients. The communicative functions that you perform will be noted on a chart along with sample communications. The initial observation period will be one four-hour period. It may be necessary to have one other period.

Information will be available to you about the study. I will answer any questions that you may have regarding the project. In the course of the observations you may withdraw for any reason without prejudice. There will be no penalty should you decide to do so.

The professional services which you provide in your employment setting will neither be enhanced nor diminished as a result of your decision to volunteer or not to volunteer in this project. These same services will neither be enhanced nor diminished as a result of your decision to decline to reply to any question or to withdraw from the project.

All information I observe and note down will remain confidential. In reporting the data all individuals' identity will be concealed.

It is possible that some of the material observed and noted will be used for publication in a professional or scientific journal.

If this is the case, the material will be carefully checked again regarding individually identifying information.

I, the undersigned, have read the above information, understood it fully, and wish to participate in the study.

Date:_____

Signature:_____

Principal Investigator:
Jo Linda Hadley RN, BA, BS
1605 Elizabeth Street
Pasadena, California 91104

Faculty Advisor
Mrs. Betty Chastain
AL/TESOL
1539 Howard Street
William Carey International University

(This form adapted from a UCLA Nursing Thesis, Smith 1987)

APPENDIX F

INFORMATION SHEET: NATIVE NURSE

This information will help me to know about the participants in this study .

1. What is your native country? _____

2. What is your native language? _____

3. Where did you receive your nurses' training? _____

If you received training in more than one country write the name of each country.

_____ _____

4. How many years of nurses' training have you had? Please circle the closest number of "school" years.

1 2 3 4 5

1 1/2 2 1/2 3 1/2 4 1/2

5. Your Age _____

6. How long have you worked as a nurse in the U.S.?

_____years _____months

7. How long have you worked at this hospital?

_____years _____months

8. What area (unit) do you work in now? _____

9. How long have you worked in this area (unit)?

_____years _____months

10. What areas have you worked in (in the past) at this hospital?

_____

APPENDIX G

INFORMATION SHEET: NON-NATIVE NURSES

This information will help me to know about the participants in this study.

1. What is your native country? _____

2. What is your native language? _____

3. Where did you receive your nurse's training? _____

If you received training in more than one country write the name of each country.

_____ _____

4. How many years of nurse's training have you had? Please circle the closest number of "school" years.

1 2 3 4 5

1 1/2 2 1/2 3 1/2 4 1/2

5. How many years of English instruction have you had in your own country or other non-English speaking countries? Circle the number of the total number of years.

1 2 3 4 5 6 7 8 9+

6. How many years of English instruction have you had in the U.S. or other English speaking countries? Circle the number of the total number of years.

1 2 3 4 5 6 7 8 9 9+

7. How many years have you been in the United States?

_____year(s) _____month(s)

8. Have you lived in other English speaking countries?

( ) yes

( ) no (if no, please go on to Question 12)

9. If yes, (you have lived in other English speaking countries) please write in which one(s) and the number of years and months spent in each one.

NAMES OF COUNTRIES	YEARS	MONTHS
_____	_____	_____
_____	_____	_____

10. Have you worked as a nurse in English speaking countries other than the U.S.?

( ) yes

( ) no (if no, please go on to Question 11)

11. Please write in which one(s) and the number of years and months spent in each one.

NAMES OF COUNTRIES	YEARS	MONTHS
_____	_____	_____
_____	_____	_____

12. How long have you worked as a nurse?

_____year(s) _____months

13. How long have you worked as a nurse in the U.S.?

_____year(s) _____months

14. Your Age_____

15. How long have you worked at this hospital?

_____years _____months

16. What areas (units) have you worked in (in the past) at this hospital?

_____ _____

17. What area (unit) do you work in now? _____

18. How long have you worked in this area (unit)?

_____year(s) _____months

19. Have you had any English language instruction since you have been working in this hospital?

( ) yes

( ) no

If yes, how much English language instruction have you had?

_____year(s) _____months

20. If yes in #19 what kind of English language instruction have you had in this hospital? Check as many as you have had.

( ) Private tutor

( ) Adult Education ESL classes

( ) Instruction at a private institution

( ) English for hospital personnel

( ) Other English classes (please explain)

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